

S. HRG. 108-663

**VA CAPITAL ASSET REALIGNMENT FOR
ENHANCED SERVICES INITIATIVE**

HEARING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ONE HUNDRED EIGHTH CONGRESS
FIRST SESSION

SEPTEMBER 11, 2003

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VA CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES INITIATIVE

THURSDAY, SEPTEMBER 11, 2003

U.S SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 2:18 p.m., in room SR-418, Russell Senate Office Building, Hon. Arlen Specter (chairman of the committee) presiding.

Present: Senators Specter, Hutchison, Miller, and Nelson.

OPENING STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

Chairman SPECTER. Good afternoon, ladies and gentlemen. The hearing of the Senate Veterans' Affairs Committee will now commence.

Our hearing today is on the Veterans Administration's Capital Assets Realignment for Enhanced Service plan. This is a major undertaking by the Department of Veterans Affairs to analyze existing health care facilities and make a determination what new facilities are necessary; what existing facilities are obsolete; and how better care can be delivered to our nation's veterans.

We approach this issue with a good deal of skepticism in the veterans' community. I believe that is something that we have to face very, very candidly. The budget constraints have been restrictive. We have not been able to take care of the influx of veterans, as we have an aging World War II population; an aging Korean population; the Vietnam War; the Gulf War; and now, most recently, the war in Iraq, so that there have been very, very heavy demands placed upon the Veterans Administration.

My own experience with the VA goes back to my childhood, where my father, Harry Specter, a veteran of World War I, was treated at the veterans' hospital in Wichita, Kansas. My dad was an immigrant. He came from Ukraine; walked across Europe with barely a ruble in his pocket to the United States; did not know that he had a round-trip ticket to France, not to Paris and the Follies Bergiere but to the Argonne Forest, where he was wounded in action; carried shrapnel in his legs until the day he died. And in the late thirties, with the tremendous economic problems of the Depression, the veterans' hospital was a godsend for my father.

I visited it not too long ago. It is now inside the city. When he was there, I had a long bicycle ride out. But it was worth the ride, because there was a free pinball machine there when I got to the end of the road.

But my own experience has shown me, including my extensive travels as chairman of this committee and, before that, as a member of this committee; and earlier this week, I was in Pittsburgh, where there is a proposal to close down a large facility known as Highland Drive, which is a mental institution for 1,000 people. I saw the empty spaces there. Just about 150 people are there, and there is a plan to buildup a fairly close facility on University Drive. But there are very grave concerns as to whether the other facility will be completed before the first facility is closed down. That is understandable. And that is something we have to address.

The veterans ask questions about will the appropriations be there? Last Monday was the day after the President had addressed the nation, seeking \$87 billion for Iraq. I said to the veterans even the President does not know if he is going to get the appropriation. But I assured them that I thought that our chances of getting that done were good.

There are many, many facilities. I know the Senator from Texas has concerns about Waco. These are matters which we will have to take up in some detail, but this committee intends to pursue with diligence an analysis as to what this plan is and to work with the Veterans Administration. We know you are operating with good intentions to try to do the best we can for the veterans.

In the absence of the ranking member, let me turn, on the early bird rule, to the Senator from Nebraska, Senator Nelson.

**OPENING STATEMENT OF HON. E. BENJAMIN NELSON,
U.S. SENATOR FROM NEBRASKA**

Senator NELSON. Thank you very much, Mr. Chairman.

I know that you hail from Kansas, the State just south of Nebraska, but you are probably a Penn State fan, and Nebraska will wrestle with Penn State Saturday night. So I thought I should remind you of that.

[Laughter].

Senator NELSON. But I do want to thank, first of all—

Chairman SPECTER. You did not have to remind me, Senator Nelson.

[Laughter].

Chairman SPECTER. The only part that surprised me was that you did not propose a wager.

[Laughter].

Senator NELSON. I was very good at wagers until we had a seven and seven season, so I—

[Laughter].

Senator NELSON. When you learn humility the hard way, the lesson is well-remembered.

However, first of all, I want to thank our panelists and the witnesses for being here today. The veterans' issues are issues that are on everyone's minds these days, and trying to come to terms with the way to match the resources with the needs has been part of what our witnesses have been involved with for a long period, and I want to commend my good friend, Secretary Principi. It is always good to see you, and I know how difficult it must be for you at times or for all times to hear that people have concerns, some

skepticism about the best plans that you are proposing, and you are here today to hear it again.

But I do know that you are committed to doing what you think will be best for our nation's veterans, both our current veterans and, unfortunately, the veterans we are generating every day in new engagements. So thank you for being here and for the opportunity.

After the merger of VISN 13 and 14 was announced to form VISN 23, you very graciously and honorably came to Nebraska to discuss the impact it would have on our veterans, and I know everyone there has appreciated that. The merger process was a good example of the importance of including the concerns of those directly impacted by these decisions, and I appreciate the efforts of the VA to incorporate concerns from stakeholders such as the veterans service organizations and Network Leadership, the VA employees, VA affiliates and collaborators under the CARES process.

I have reviewed both VISN 23 recommendations for enhanced care as well as the draft national plan, and I would like to take a moment to express some of those concerns that I mentioned regarding the community-based outpatient clinics, the CBOC's, to the realignment of some small facilities and, three, of course, the issue of long-term care needs, which are changing daily with the creation of new veterans' needs at the present time.

Currently, only 51 percent of our Nebraska veteran enrollees are within the VA driving guidelines for primary care, the guidelines being 30 minutes for urban and rural areas and 60 minutes for highly rural areas. As you are aware, VISN 23 is the most rural VISN, as we understand it. In order to resolve the gap in access to outpatient care, VISN 23 established a planning initiative to develop CBOC's in Bellevue, Nebraska; Holdridge, Nebraska; O'Neill, Nebraska; and Shenandoah, Iowa; and to increase the capacity at the existing CBOC in Norfork, Nebraska.

According to the CARES planning initiatives and market plans, the rationale for selection of these sites, the rationale was based on the population of enrollees that lack access in these areas. By establishing the CBOC's, it would increase the access level to 64 percent of enrollees by 2012 and up to 67 percent by 2022, with the ultimate target being 70 percent.

During the network review process, there was wide support exemplified, with 80 percent of stakeholder comments agreeing and supporting this proposal. So not all is as from the dark side as we might have initially been concerned or thought with the concerns being taken into consideration.

Chairman SPECTER. Senator Nelson, you are past the 5-minute mark. Do you intend to be longer?

Senator NELSON. No, no. I will submit the rest of the written statement. But what I wanted to do was indicate that there are efforts underway to work with the stakeholders. We appreciate that. But we have got such a long direction to go with the new veterans and the changing in the demographics as time goes by that we need to continue to work together. I will submit the rest of my statement, Mr. Chairman, for the record, but thank you very much for this opportunity.

PREPARED STATEMENT OF HON. E. BENJAMIN NELSON, U.S. SENATOR
FROM NEBRASKA

Good Afternoon. I would like to thank all of the witnesses for appearing here today to discuss the services our veterans have earned and received. Secretary Principi it is always good to see you again. After the merger of VISN 13 and 14 was announced to form VISN 23, you came to Nebraska to discuss the impact it would have on our veterans that was greatly appreciated. The merger process was a good example of the importance of including the concerns of those directly impacted by these decisions. I appreciate the efforts of the VA to incorporate concerns from stakeholders, such as, Veteran Service Organizations, Network Leadership, VA Employees, VA Affiliates and Collaborators into the CARES process.

I have reviewed both VISN 23 recommendations for enhanced care as well as the draft national plan, and I would like to take a moment to express some concerns regarding: (1) Community Based Outpatient Clinic's (CBOC's), (2) Realignment of Small Facilities, and (3) the issue of Long-Term Care needs.

Currently, only 51 percent of Nebraska Veteran enrollees are within the VA driving guidelines for Primary Care, the guidelines being 30 minutes for urban and rural areas and 60 minutes for highly rural areas. In order to resolve the gap in access to outpatient care, VISN 23 established a planning initiative to develop Community Based Outpatient Clinics (CBOC) in (1) DOD/Bellevue, NE; (2) Holdrege, NE; (3) O'Neill, NE; (4) Shenandoah, IA; and (5) increase the capacity at the existing CBOC in Norfolk, NE. According to the CARES planning initiatives and market plans, the rationale for selection of these cities were based on the population enrollees that lack access in these areas. By establishing these CBOC's it would increase the access level to 64 percent of enrollees by 2012 and 67 percent by 2022 with the target being 70 percent. During the network review process, there was wide support exemplified with 80 percent of stakeholder comments agreeing and supporting this proposal.

Therefore, I was concerned when the draft national plan classified these CBOC initiatives in the priority 2 category. To qualify as priority 1 a market must demonstrate a larger future outpatient capacity gap, large access gaps and the number of enrolled who do not meet access guidelines is greater than 7,000. According to 2001 VA data, Nebraska has 52,022 enrollees and only 51 percent of these meet the access guideline, leaving 49 percent or 27,696 total enrollees outside of the driving guidelines.

I believe by placing all of these CBOC proposals effectively in the priority 2 category that rural areas of Nebraska will not see improvements in the near future and will be penalized in comparison to more urban areas with a larger number of enrollees. Once again, 49 percent of Nebraska enrollees are outside of the driving guidelines; meaning the Department of Veterans' Affairs is providing access to Primary Care only half of the time for Nebraska's Veterans. I find this statistic deeply troubling. Nebraska veterans, who sacrificed just like other veterans, should not be penalized because they live in a densely populated area. Therefore, I support the network proposal and advocate that these 4 CBOC recommendations be included in the priority 1 category.

My second concern is in regards to the inclination to transition some smaller facilities from Acute Care Hospitals to Critical Access Hospitals. I am of the understanding that the VA is currently using the Medicare definition of a CAH: (1) must have no more than 15 acute beds, and (2) cannot have lengths of stay longer than 96 hours and (3) maintain a strong link to their referral network. The national plan proposed that the CAH model be implemented at the Cheyenne VA Medical Center (VISN 19) and at the Hot Springs VA Medical Center (VISN 23).

921 Nebraska veterans utilize the Cheyenne Medical Center in Cheyenne, Wyoming. In the past fiscal year these veterans were served by 3,578 visits with an average length of stay for acute care at about 130 hours—above the 96 hours threshold for CAH model. The national plan's focus for this facility is to maintain acute bed sections, develop more restrictive parameters for types of in house surgery procedure and close all ICU beds. The recommendation to convert this facility to a CAH model however was not included in the network proposal. Consequently, I have received a significant amount of feedback from local veteran service officers, organizations, facility employees and veterans concerned that this recommendation was suggested late in the CARES process leaving little feedback time for shareholders and many veterans feel they will see a continual decline in services at the Cheyenne Medical Center.

2,590 Nebraskan veterans are registered at the Hot Springs Medical with an average length of stay for acute care at about 72 hours—conforming to the CAH model. The focus for this facility is to decrease bed numbers and increase contracts and re-

ferrals. Many Nebraskan veterans are concerned about downsizing this facility especially when there is a clear need for continued inpatient services based on the local domiciliary home and State veteran's home both located on the Hot Springs Campus.

And the last concern I would like to address is in relation to Long Term Care for our nation's veterans. The VA has acknowledged that veteran's age 75 and older will increase from 4 million to 4.5 million veterans by 2010. GAO has estimated that veterans 85 and older will triple by 2012. Considering this increase, the VA will need all the facilities they can build and maintain to plan for this increase. Cutting facilities, as the draft CARES plan does, will not make this problem go away and will only mean that another Administration is forced to deal with it in the very near future. Thank you again for appearing before the Committee to address our concerns.

Chairman SPECTER. Senator Hutchison.

**OPENING STATEMENT OF HON. KAY BAILEY HUTCHISON,
U.S. SENATOR FROM TEXAS**

Senator HUTCHISON. Thank you, Mr. Chairman.

I want to thank you for scheduling this hearing, because it has reverberations throughout my State as well as throughout the country, I am sure. All of us who serve on this committee understand the need for the Veterans Administration to examine all of the medical services provided to our veterans and to realign the requirements, where necessary, to address the greatest need. We also recognize the need for the Veterans Administration to make the best possible use of our resources.

I am concerned, however, that the draft plan, as it impacts my state, neither enhances services nor wisely allocates resources. I recognize that we are only in the second step of a four-step process and that neither the independent commission nor Secretary Principi have reviewed these initial recommendations. I am confident that the commission and Secretary Principi will closely evaluate them.

The release of the draft plan caught many in Texas by surprise. If the draft plan had been adopted as written, many in Marlin, Big Spring and Waco, the communities most affected by the proposal, fear they will lose access to veterans' medical care. The plan would result in a drastic reduction in current services. Prior to the release of the draft plan, our veterans' organizations and local community leaders worked with their respective service network regional directors in developing plans to optimize use of their facilities.

But the draft plan that appeared in August bore almost no resemblance to the original recommendations by the service network directors in the field. For example, the Veterans Integrated Service Network Market Plan recommended establishing Waco as a regional psychiatric resource and spoke of an enhanced mission for the Waco facility. Considering that the VA has spent over \$80 million over the past decade building state-of-the-art psychiatric facilities in Waco and training technicians and nurses in this specialized field, the original recommendation to consolidate psychiatric services seemed to be a good use of taxpayer funds. However, the recommendations were disregarded, and closure was recommended.

Similarly, in Big Spring, and I would like to say that the Mayor of Big Spring, Russ McEwen, and the Howard County Commissioner, Bill Crooker, are in the audience, if you would stand. They are so concerned about this. We appreciate your being here.

Let me tell you the story of Big Spring. They serve a veteran population spread over 74,000 square miles in an area equal in size to New York, New Jersey, Connecticut, Rhode Island, Massachusetts and Delaware combined. Big Spring VA Hospital serves 63,000 veterans. It would be inconceivable to imagine a recommendation to close a hospital in Delaware and send veterans to be treated in Massachusetts, but that is comparable to what is being done to Big Spring if that facility is closed or severely downsized.

As was the case in Waco, the veterans' community in Big Spring worked with the VISN to make a strong case about the central location, and as I said this morning, even the mayors of Midland and Odessa, where there would be a proposed new facility, have written saying no, it should stay in Big Spring, where it is more central. So I think that we can understand that there was a shock for the report that came out after working with the VISN.

I recognize the need for the independent evaluation. Communities like Big Spring, Waco and Marlin need to have a strong justification to keep their facilities in place. But I am concerned that we are on such a fast track that maybe these communities might not get the full time and have the ability to fully prepare their defense. So I hope that we will not make mistakes in closing facilities too quickly but that there will be a good, solid timeframe for these communities to meet and have business plans to say what the community would like to do to upgrade the facility and make it more worthwhile.

The mayors of these cities with whom I have met: Waco and Big Spring and Marlin, all say that they are willing to do that. My final comment is for Mr. Alvarez. We want to say how much we respect you and the record that you have. You have undertaken a thankless task and one that really shows the American spirit that you have already shown in your service career that you would undertake it. I would just ask that you look at the original recommendations in addition to the most recent ones to see what the regional people brought forward, because I think they shed a lot of light on this process.

Finally, Mr. Chairman, let me say: no secretaries or assistant secretaries have been as open to discussion, as forthcoming, as accessible as Secretary Principi and Secretary Roswell. I have met with both of them. I have talked to them. I know that their hearts are in the right place, but they could not be more accessible, and I appreciate that. I just hope that in the end, there will be an ability by the communities to offer things that would be better for the veterans' hospital, to make it better and also to look at these original proposals that were made from the field where the service is really being done.

With that, I thank you very much.

Chairman SPECTER. Thank you, Senator Hutchison.

Senator Miller.

**OPENING STATEMENT OF HON. ZELL MILLER, U.S. SENATOR
FROM GEORGIA**

Senator MILLER. Thank you, Mr. Chairman. Thank you for holding this hearing, and I would like to thank Secretary Principi and

Dr. Roswell and Mr. Alvarez for being here with us and for the great job that they do every day.

I think it is very important and timely that the Veterans Administration address health care and other concerns of the soldiers, because military service should be a career of distinction and honor. I know you believe that as strongly as I do and that those who serve should be given the resources they deserve.

With troops still facing danger and a new generation of soldiers using VA health care, ensuring access to health care services has become paramount. But I also want to say that just as important as accessibility is ensuring that veterans receive health care in a timely manner as well. We have all heard the stories of veterans waiting 6 months to see a VA physician. Those delays are too common across this country, and we have got to address this problem.

I applaud the goal of the CARES commission, and I believe the result of the commission's hard work will be more comprehensive and more accessible health care for all of our veterans. I am optimistic. I realize that there are going to be changes that are not going to please everyone, but I also understand that the Department of Veterans Affairs, just like every other department and just like the Senate and Congress should get as much bang out of the buck as we possibly can. It is not Government money; it is taxpayers' money. We have got to operate the most efficient system of veterans' health care without compromising our mission.

We have the best military in the world, and our soldiers put their lives on the line for this country every day. As you well know, Georgia is home to 770,000 veterans, and it was Georgia soldiers that made up the bulk of our troops deployed to the Middle East. So it is critically important for the VA to guarantee that they will have access to quality health care facilities when they return home.

So as the CARES initiative progresses, it is vital for the Veterans Administration to preserve its commitment to veterans. I know you understand that. I also want you to know that I will continue to work to make certain that the VA remains dedicated to improving health care for veterans in Georgia and nationwide, and it is my hope that Congress and the administration can work together to find solutions to adequately address VA's budget concerns while still providing the quality health care that we all know our veterans deserve.

Thank you.

Chairman SPECTER. Thank you very much, Senator Miller.

We now turn to the distinguished Secretary of Veterans Affairs Anthony J. Principi. Secretary Principi comes to this job with superb qualifications I think never before matched, in that he had previously served as Deputy Secretary of Veterans Affairs under President George H.W. Bush. He had served as chief counsel and staff director for the Senate Committee on Veterans' Affairs, which is a tough job and a great learning experience, and previous to that, he had been chief counsel for the Committee on Armed Services. So he has quite a legislative background and quite an executive background.

A graduate of the U.S. Naval Academy, he had been in the private sector when President Bush brought him back to government. He was confirmed on January 23, just 2 days after inauguration

day, and even though Secretary Principi has not made judgments in the area, because the recommendations have not yet come to him, it is he who started the process on his determination, as he saw it, to give the veterans the best possible care.

We customarily set the time limit at 5 minutes, and when I start the proceedings with a time limit, I like to point out that recently, on the memorial services for Ambassador Annenberg, the time limit was set at 3 minutes for President Ford and Secretary Powell and Arlen Specter and others. So it should be noted that 5 minutes is a large allocation by some standards.

[Laughter.]

Chairman SPECTER. Secretary Principi.

**STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, U.S.
DEPARTMENT OF VETERANS AFFAIRS, WASHINGTON, D.C.**

Secretary PRINCIPI. Thank you, Mr. Chairman. Thank you for your time. Good afternoon, Mr. Chairman and members of this Committee. I appreciate the opportunity to discuss the VA's Capital Asset Realignment for Enhanced Services initiative, usually referred to as CARES.

CARES is rooted in the answer to the question: how can VA and the Congress best allocate the limited resources available to support our vast infrastructure—well over 5,000 buildings; well over 15,000 acres of land across the country—so as to ensure that veterans receive the best possible care over the decades to come in this new century? Many of our hospitals were built, designed for medicine as it was practiced after World War II and, in many cases, even after World War I, when we inherited old Army forts from the military, and they became VA hospitals in the late 1800's and early 1900's.

Then, lengthy inpatient admissions were the norm. Today, as you well know, new procedures, advances in technology, new drug therapies have moved most care to an ambulatory outpatient arena and dramatically reduced the length of stay when inpatient care is still required. Then, the mentally ill were locked away for decades at a time behind closed doors. Today, most can be treated in their communities with revolutionary new drugs like atypical antipsychotics, where they can live at home; they can go to work as long as they have the new drugs and the community and non-institutional care support.

Telemedicine, digital radiology, allow physicians literally hundreds if not thousands of miles away from physicians to provide the latest diagnostic treatment and care with the veteran in their community wherever that might be. Then, many facilities were located with little regard to where veterans live at the time, much less where they will be living in the third decade of the 21st Century.

As you know, in 1999, GAO testified that maintaining obsolete or duplicative structures diverts \$1 million a day every day, every year, away from the care of veterans. It is for those reasons that the last administration initiated the CARES process and why I believe it was important to carry it forward. My goals are simple: provide our doctors and nurses with the facilities they will need to provide 21st Century veterans with 21st Century medical care; create a plan for managing our capital assets over the next two dec-

ades that will optimize the practice of modern medicine while acknowledging the inevitable changes in veterans' demographics.

The parameters I set are clear. The plan must ensure that VA's capacity to provide care, including our specialized services such as mental health and spinal cord injury, is not reduced. Nor do I want a plan that does not comply with the statutory requirements for long-term care. As you know, we initiated the process with a pilot in Network 12, basically northern Illinois and Wisconsin. Implementation of the plan for that network is underway. We learned a lot about our process in that pilot project. It was very expensive. We paid contractors and consultants millions to do what we could do for ourselves. Veterans and other members of the community said that they did not have a chance to provide input, and the process was very slow.

We owe it to our veterans, to our health care providers, to our communities as well as to the American people to get our capital asset planning house in order quickly. Our appropriations committees have made it clear that we must produce a well-thought-out and comprehensive capital plan before they will entrust us with significant construction funding, even for patient safety and seismic protection projects.

In real dollars, the past 5 years have seen construction funding at one-tenth the rate we received in the 1980's. That will not change until our project proposals reflect a plan for 21st Century medicine. I addressed this challenge by directing the Undersecretary for Health to produce a plan based on information developed with data on local facilities and demographics and with input at the local level, from the veterans we serve, our employees, our affiliates and our communities. I further directed him to meld this input into a comprehensive plan for an integrated national health care system, but I also wanted a reality check.

To get that check, I commissioned an independent body, the CARES Commission, to evaluate the Undersecretary's plan, to independently obtain stakeholder input and to provide their independent judgment to me on the plan prepared by the Undersecretary. To lead the commission, I chose Mr. Everett Alvarez, the gentleman to my right, a former VA deputy administrator; a veteran whose courage and integrity were forged as a naval aviator and tested as a POW for 8 years in Hanoi and a man whose commitment to America's veterans is absolutely unquestioned.

Under his leadership, the commission will make such modifications as they deem appropriate and present their report to me. I will then review this report very carefully; consult with Members of Congress; and then accept the plan in its entirety or reject it or ask the commission to go back and answer further questions, but I will not pick, and I will not choose among the recommendations and proposals.

When the process is completed, I expect that we will have a road map for managing VA's capital assets for the next 20 years. I fully expect the plan to call for significant capital expenditures. I do not delude myself that the plan will call for leaving every VA facility intact as it exists today. I do expect that implementation of the plan will mean better health care for more veterans of this nation.

Thank you, Mr. Chairman for the opportunity to testify before you today.

[The prepared statement of Secretary Principi follows:]

PREPARED STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY,
U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee:

I am pleased to appear before the Committee to describe the process that produced VA's Draft National CARES Plan, which represents the most comprehensive effort to develop a road map that will guide the allocation of capital resources within the Veterans Health Administration (VHA). With me today is Dr. Robert Roswell, VA's Under Secretary for Health, who will discuss the contents of the draft national plan itself.

CARES is a comprehensive, data-driven planning process that projects the future demand for health care services in 2012 and 2022, compares them against the current supply, and identifies the capital requirements and the asset realignments VA needs to improve access, quality, and the cost effectiveness of the VA health care system.

VA initiated CARES to create a strategic framework to upgrade the health care delivery capital infrastructure and ensure that scarce resources are placed in the types of facilities and locations that would best serve the needs of an aging veteran population with increased acute and outpatient care needs. The dramatic changes in the delivery of VA health care services including the expansion of outpatient services, an aging infrastructure with the average age of buildings over 50 years, costs associated with the maintenance of excess space, and the potential use of underutilized campuses to provide revenues to enhance services were powerful factors that coalesced into the need for CARES. GAO's 1999 reports, which were critical of the management of vacant space within VHA, and Congressional reluctance to provide capital without an overall assessment of the current and future capital requirements to meet the health care needs of veterans have reinforced the importance of a comprehensive capital plan.

The CARES Process was designed to balance the need for a national planning process with the recognition that health care delivery is local. This was accomplished through the use of national data bases that standardized the forecasts of enrollment and utilization, the identification of national planning topics, and the use of standardized tools in determining how to meet the projected needs. Forecasts of enrollment and the need for outpatient and inpatient care were developed through the year 2022 for each VISN and market area. Data were integrated with Medicare to ensure forecasts reflected Medicare utilization. All VHA space was assessed for functionality and safety. Based upon these data, a national planning agenda was developed and sent to the field for solutions. A standardized costing and decision support system assisted in the planning. The agenda included the development of cost effective solutions to meet the future space requirements, the mission of small facilities, reduction in vacant space, consolidations and realignments of services and campuses and collaboration with DoD. Stakeholder input was required and occurred at the national and field levels. Seventy-four market plans were submitted as input to the development of the Draft National CARES Plan.

CARES was initiated in a Pilot in VISN 12 in 1999. The CARES process focuses on markets—or distinct veteran population areas. The Phase I pilot identified three market areas: the Chicago area, Wisconsin and the Upper Peninsula of Michigan.

In this initial effort, the contractor assessed veterans' health care needs in the test market and then formulated various solutions that could meet those needs. Following a detailed review process a plan to realign capital assets in the VISN 12 market areas was approved. The results of CARES Phase I were announced in February 2002.

In preparing for CARES Phase II extension of the process to the remaining 20 VISN's, I determined that VA personnel, rather than contractor staff, would coordinate and carry out the planning process. The conversion from a contracted study in one VISN, to a VA-operated planning process extended to the entire system, went well beyond the scope of the pilot. The use of VA staff was necessary to ensure that a process was created that would be ongoing and become part of VA strategic planning process rather than a one time study performed by outside consultants.

In effect, CARES Phase II piloted a new process that will be integrated into a redesigned strategic planning process. The challenge of developing a national process while recognizing that health care is delivered through local systems required a new approach that included the following elements:

- use of national data bases and methodologies to determine current and future needs;
- assessment of all space in VHA for its safety and functionality;
- national definition of the planning initiatives to be addressed by VISN's. VISN development of plans that address the planning initiatives;
- standardized planning support systems and data for plan development and costing to ensure consistent results;
- policy and tools that supported local and national stakeholder involvement;
- onsite technical support to the VISN's for plan development; and
- detailed national review process to create a national plan from the VISN plans.

A major enhancement in the Phase II model was increased commitment to the aggressive, systematic inclusion of stakeholders. The requirement for in-depth communications with a vitally interested public at national, regional, and local levels was integral to the process. Multiple modalities and media were designed and used to inform stakeholders about CARES in general and to solicit their comments on potential changes in respective markets in particular.

NINE-STEP PLANNING MODEL

The enhanced CARES model comprised a nine-step process designed to ensure consistency in the development of CARES Market Plans within each VISN.

STEP 1: IDENTIFY MARKET AREAS AS THE PLANNING UNIT FOR ANALYSIS OF VETERAN NEEDS

The VISN's identified 74 market areas based on standardized data for veteran population, enrollment, and market share provided by HQ. Each network also used local knowledge of their unique transportation networks, natural barriers, existing referral patterns, and other considerations to help select their market areas.

STEP 2: CONDUCT MARKET ANALYSIS OF VETERAN HEALTH CARE NEEDS

A national actuarial firm—referred to hereinafter as CACI/Milliman—that had developed enrollment, workload, and budget projections for VA budget development, under VA direction modified the model to develop standardized forecasts of future enrollees and their utilization of resources from 2002 through 2022 for each market area in all VISN's. Translation of the data into the VHA CARES Categories listed below facilitated the identification of “gaps” between current VHA services and the level or location of services that will be needed in the future. These were “high level” macro categories that would enable planning to occur at a level of detail adequate for capital needs rather than detailed service-level planning: Inpatient Medicine; Outpatient Primary Care; Inpatient Surgery; Outpatient Mental Health; Inpatient Psychiatry; Outpatient Specialty Care; Outpatient Ancillary and Diagnostic Care.

The model also projected workload demand in the following categories, which were not used to identify gaps because private sector benchmark utilization rates were not available to validate results: Residential Rehabilitation; Intermediate/Nursing Home Care; Domiciliary; Blind Rehabilitation.

Spinal Cord Injury

Since the statistical model's data validation on these non-private sector services was not adequate for objective planning, these categories were either removed from the Phase 1/ cycle (Le., held constant) or, as in the case of Blind Rehabilitation and Spinal Cord Injury, alternative forecasting models were developed by teams of VA planners and VHA experts from the concerned special disability programs, who collaborated to produce these unique projections.

Data on the current supply and location of VHA health care services were collected for all facilities, markets, and VISN's. In most instances, fiscal year 2001 was used as the source year for baseline data. A profile was created for each VISN and made accessible to VHA staff on a web site established as the repository for all CARES data. Baseline data included:

- Space (condition, capacity and current vacant space)
- Workload (fiscal year 2001 bed days of care and clinic stops)
- Unit Costs (facility specific in-house and contract unit costs)
- Special Disability Population Data
- Access Data
- Facility List
- Research Expenditures and Academic Affiliations
- Clinical Inventory
- Potential DoD, VBA and NCA Collaborations

- Enhanced Use Lease Valuations
- Summary of VISN fiscal year 2003/fiscal year 2007 Strategic Plans

STEP 3: IDENTIFY PLANNING INITIATIVES FOR EACH MARKET AREA

Data collected in Step 2 made it possible to directly compare current access and capacity, with quantitative projections of future demand. "Gaps" were indicated in any market where actual utilization in fiscal year 2001 was significantly less than utilization projected for fiscal year 2012 and fiscal year 2022. Such gaps in various market areas formed the basis for the development of "planning initiatives"—essentially a description of the potential future disparity between capacity and need.

Planning Initiative Selection Teams were formed and selected planning initiatives for each VISN and Market Area based on established criteria for planning remedial action. Planning Initiatives were identified in the following areas:

- Access to Health Care Services
- Outpatient Capacity (Primary Care, Specialty Care, Mental Health). Inpatient Capacity (Medicine, Surgery, Psychiatry)
 - Special Disabilities (Blind Rehabilitation, Spinal Cord Injuries and Disorders)
 - Small Facilities
 - Consolidations and Realignments (Proximity)
 - Vacant Space
 - Collaborative Opportunities (DoD, VBA, NCA)

In addition to the Planning Initiatives, all workload changes that resulted in gaps between predicted demand and current supply had to be planned for, including in-house provision of services or by contracting, sharing, or other arrangements. The requirement to manage all projected workload was a significant addition to the planning process; it was included in order to assure that all space needs were addressed in the National CARES Plan. The Planning Initiatives and their data were transmitted to the field in November 2002 to begin the market planning process.

STEP 4: DEVELOP MARKET PLANS TO ADDRESS PLANNING INITIATIVES
AND ALL SPACE REQUIREMENTS

The selected planning initiatives formed the key elements of the VISN CARES Market Plans. All VISN's developed market plans, which included a description of the preferred solution selected by the VISN for all planning initiatives identified in every market as well as potential solutions considered to address each planning initiative.

VISN planning teams were expected to identify alternative solutions for their plan development process. In proposing these various alternative solutions, VISN planners were required to assemble specific supportive data, which were entered into the IBM-developed market-planning tool. The standardized algorithms in the market planning tool assured a consistent methodology for analyzing each solution's impact on workload, space and cost, as well as other CARES criteria such as quality, access, community impact, staffing, and others.

Thus, all VISN's used the same criteria and planning tool (using local operating and capital costs) to determine the relative merits of meeting future demand via contract, renovation of available space, new construction, sharing/joint ventures/enhanced use or acquiring new sites of care. VISN's briefed stakeholders on their planning initiatives, and presented their proposed solutions. Comments and other feedback from stakeholders were duly noted for incorporation into the planning process. VISN market plans were submitted to VHA Headquarters on April 15, 2003.

STEP 5: VACO REVIEW AND EVALUATION: DEVELOPING THE DRAFT
NATIONAL CARES PLAN

The VISN plans served as input to the development of the Draft National CARES Plan. The Draft National CARES Plan is not a compilation of individual VISN plans. It represents a comprehensive series of national decisions made after reviewing the individual VISN Market Plans. Each VISN CARES Market Plan was subjected to an extensive tri-partite review before ultimately being considered by the Under Secretary for Health for inclusion in the Draft National CARES Plan. The groups conducting the reviews were field and headquarters review teams organized by the National CARES Program Office, the Clinical CARES Advisory Group (CCAG), and the CARES Strategic Resource Group (also known as the "One VA Committee"). The clinical experts (CCAG) provided the most rigorous review and comments on issues with medical and other direct care (including mission-related) implications, while the Strategic Resource Group took a more generalized management approach, looking especially closely at matters concerning collaboration with other departments or administrations.

The National CARES Program Office performed a comprehensive and intensive review, assembling review groups to look at similar types of planning initiatives from all VISN's, assuring a structured assessment that was consistent across the VA system as well as an overall assessment of whether the individual solutions within a market added up to a sensible market plan.

The final review was by the Under Secretary for Health, who reviewed the key issues and the comments from the diverse review groups and stakeholders. As a result of the Under Secretary for Health's review of the adequacy of the market plans, selected VISN's were required to review the potential realignment of specific facilities/campuses and to consider the feasibility of conversion from a 24-hour/7day-per-week operations to an 8-hour-per-day/40-hour-per-week type of operation. The rationale for the requested review was to fully assess the potential to consolidate space and improve the cost effectiveness and quality of VA's health care delivery. The guidance included the continuation of all services to veterans as part of the realignment review. The results of this initiative were completed in July 2003 and incorporated into the draft National CARES Plan.

The product of the Under Secretary's review process and policy decisions formed the draft National CARES Plan that I transmitted to the CARES Commission on August 4, 2003.

STEP 6: INDEPENDENT COMMISSION REVIEW

I established the CARES Commission in December 2002 to provide an objective and external perspective to the CARES process. It is not expected to provide a 'de novo' review of the VA medical system. Rather, the Commission is charged with reviewing the Under Secretary's Draft National CARES Plan so that it can make specific recommendations to me regarding the realignment and allocation of capital assets needed to meet the demand for veterans' health care over the next 20 years.

At the first of its monthly meetings, in February, I asked the Commission to examine the Draft Plan with a critical and independent eye; I also asked the Commission to report to me on the validity of the opportunities identified in the Plan for improving our ability to provide quality healthcare for veterans by effective deployment of physical resources.

The Commission is made up of 16 individuals from all walks of life: doctors and nurses, medical and nursing school professors and deans, health care professionals, members of veterans' service organizations, former VA officials, business managers and leaders in their communities. Each member brings his or her special qualifications and experiences to the Commission, as well as sensitivity to the Commission's unique mission. Chairing the Commission is the Honorable Everett Alvarez, Jr., who is best known as the first American aviator shot down over North Vietnam and who was a prisoner of war for 8½ years. Among his other accomplishments, Chairman Alvarez served as Deputy Director of the Peace Corps, and as Deputy Administrator of the Veterans Administration for 4 years.

The Commission may accept, modify or reject the recommendations in the Draft National CARES Plan. In making its recommendations, the Commission will consider information gained through nation-wide site visits, written comments from interested parties and formal public hearings. The Commission completed 59 of its 65 site visits in July, with some scheduled into this month. These informal tours through VA facilities and the geographic areas they serve have included meetings and conversations with many veterans, individuals inside the VA family, and local community leaders. The Commission has completed over half of its 36 formal public hearings, with the last one scheduled for October 3.

STEP 7: SECRETARY OF VETERANS AFFAIRS DECISION

I anticipate that the Commission will provide me their recommendations and supporting comments regarding the Draft National CARES Plan by December 2003. After reviewing their recommendations, I will make a determination to accept, reject, or refer back to the Commission for additional review or information prior to making a final decision.

STEP 8: IMPLEMENTATION

VISN's will prepare detailed implementation plans for their CARES Market Plans, which will be submitted to the Under Secretary for Health for approval. Approved market plans will be used by VISN's to develop capital proposals that will be selected for funding through a capital prioritization process that is linked to the CARES process and to subsequent strategic planning cycles.

STEP 9: INTEGRATION INTO STRATEGIC PLANNING PROCESS

As VISN's proceed with the implementation of their CARES Market Plans, the planning initiatives and proposed solutions will be refined and incorporated into the annual VHA strategic planning cycle. The integration of capital assets and strategic planning will ensure that programmatic and capital implementation proposals are integrated into current VHA strategic planning and resource allocation. The alignment of policy assumptions and strategic objectives will thus form an integrated planning process.

Mr. Chairman, in a recent article in the Washington Post, Dr. David Brown commented on VA by indicating that "VA is the most safety conscious, self aware, and in many ways the best run medical system in the country." This is high praise indeed from a well-respected physician, and it is my goal that the VA strategic planning process will in every way possible reflect the standards and performance implicitly expressed in Dr. Brown's statement. The CARES initiative is an important step in that direction. This completes my testimony. I will now be happy to answer any questions that you or other Members of the Committee might have.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BOB GRAHAM TO THE
DEPARTMENT OF VETERANS AFFAIRS

Question 1. In the market plan submitted to the Under Secretary for Health by VISN 1, officials stated they had considered "alternatives to consolidate Long Term Care (LTC) (including the Alzheimer's and SCI Units) and Psychiatry inpatient beds from the Bedford to Brockton facilities" yet, "as final projections are not available for LTC inpatient beds and earlier projections indicated a substantial increase in LTC beds, it was determined to utilize current capacities." Despite these assessments to the contrary—made by those with firsthand knowledge of the situation—VA's draft National CARES Plan proposes that Bedford instead convert these facilities into outpatient operations only. (a) How do you justify this disconnect? (b) If the conversion does take place, what will happen to those patients who rely on the Bedford VAMC's 100-bed specialized care unit for veterans with Alzheimer's disease? Please explain how VA will ensure that these veterans continue to get the long-term care services they so desperately need.

Response. VA's complete response to both questions follows question 2 below.

Question 2. In addition to its specialized care unit for veterans with Alzheimer's disease, the Bedford VAMC houses a Geriatric Research, Education, & Clinical Center (GRECC), which is widely respected for its innovative and practical clinical research on dementia care. The GRECC is also a recognized leader in providing palliative care to veterans with advanced progressive dementia. (a) How will a conversion of the Bedford facility impact the ongoing dementia research that is presently taking place at the Bedford GRECC? (b) Along similar lines, how does VA plan to continue providing palliative care services to the veterans who depend on the Center?

Response. The following response is intended to address all parts of both questions.

The realignment proposal for the Bedford campus contained in the draft National Plan provides that outpatient services will be maintained at the Bedford campus. Current services in inpatient psychiatry, Alzheimer's disease, domiciliary care, nursing home care, and other workload from the Bedford campus will be transferred to other VISN 1 facilities. The realignment process will also maintain special programs such as Alzheimer units, GRECC's (including dementia research), and palliative care, though not necessarily at the Bedford campus. The preliminary proposal included the possibility of realigning these programs to the Brockton campus. The remainder of the Bedford campus will be evaluated for alternative uses such as enhanced use leasing for an assisted living facility that would be available to veterans. Any revenues or in kind services will remain in the VISN to invest in services for veterans.

The realignment proposal is currently being refined and will specifically address the needs of all programs, including the special programs mentioned above, to ensure that patient care needs are met and will be part of the proposal that is reviewed by the CARES Commission and the Secretary. In addition, research associated with these programs will be considered in the revised realignment proposal.

The LTC planning model that is currently available does not adequately account for changes in the delivery of long-term care services and changes in disability among the elderly population. It overstates the future demand for Nursing Home beds. This model is currently under revision. As a result, in this stage of the planning process, the realignment analysis uses current nursing home capacity rather

than plan for what may be an excessive number of beds. However, if the Secretary approves the recommendation, the results of the improved forecasting model will be available and used to finalize the proposal prior to implementation planning. This will ensure that future nursing home needs are accurately assessed both for Bedford and throughout the VA health care system.

Implementation plans to effect the transfer of programs and services are not yet developed. However, the transition would take place over time and in a manner that is least disruptive to patients and their families. The final determination of the future of the Bedford VAMC is being made in successive steps to ensure that patient care services are maintained for veterans. Both the CARES Commission and the Secretary will review the realignment recommendation before the Secretary makes a final decision on the draft National CARES Plan proposal. It is the Secretary's policy that no services will be closed without alternative locations to provide these services to veterans.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO THE
DEPARTMENT OF VETERANS AFFAIRS

Question 1a. My understanding is that the VISN 20 regional VA leaders complied with all the requirements for the CARES market plan. I fail to understand why, at the very last minute—before the plans were sent on to the Commission—more than two dozen facilities, including three in Washington State, were told to re-do their plans. It looks to me that after months of reviewing VISN submissions, the VA has decided to rewrite the rules to get the response it seeks. This undercut months of work and more importantly it seems like a particularly disingenuous thing to do to our veterans groups—in Washington State and in the dozens of communities which were affected. Why was the decision made to undercut the CARES process at the 11th hour?

Response. The Under Secretary for Health requested changes to the market plans as a result of reviews conducted during preparation of the draft National CARES Plan. This review was an integral part of the design of the CARES process to ensure that the plan was truly national in scope and not simply a compilation of the individual VISN market plans. Rather than undercutting the CARES process, this review and the proposed changes to the market plans were an effort to ensure that national, system-wide issues are adequately addressed. The VISN's market plans contain the results of thousands of decisions regarding how outpatient and inpatient demand will be managed, i.e., whether space will be leased, renovated, or constructed, or whether community contracts and 000 sharing will be utilized. Almost all of these decisions are included as recommended in the market plans.

When the Under Secretary reviewed the results of the market plans, he concluded that there were opportunities to realign campuses to improve the quality, access, and resource use by examining opportunities to move these campuses from inpatient to outpatient operations, i.e. by converting from 24-hours, 7-days/week to an 8-hours, 5-days/week operations. He asked the VISN's to determine how this could be accomplished at selected sites with the provision that there would be no loss of services to veterans. He specified that inpatient services must be provided either at other VAMC's through sharing agreements or in the local community through contracts. He also stipulated that outpatient services were to be maintained on the VAMC campus or in the local community through leasing of sites or contracting for care.

The realignments focused on moving long-term care sites to locations with an acute care presence because this would also improve access to diagnostic and therapeutic services for the long-term care population. In addition, the current physical environment in many sites, such as Walla Walla and White City, would require significant capital investment in older buildings. It would be more expensive to renovate such buildings than it would be to build a new nursing home, for example. Many patients served by long-term care facilities are often more dispersed geographically than those served by acute care facilities, and where contracting is combined with relocation of beds to other VAMC's, access is likely to be improved.

With respect to the Vancouver campus, we believe we have an opportunity to put the campus to better use. It appears to be underutilized for inpatient care services, and we are exploring opportunities to improve access to outpatient services at another location.

All of the draft National CARES Plan realignments are proposals that are being further reviewed. Additional cost benefit information will be available to the CARES Commission and the Secretary prior to the final decision on the National CARES

Plan. Should the proposals be approved, detailed planning would occur as part of implementation planning.

Question 1b. Can you explain to me why headquarters desired a significantly redrawn market plan for Washington State and VISN 20?

Response. The only changes in the VISN 20 market plan involved the three facilities indicated in the realignment analysis mentioned above in our response to Part A of your question.

Question 2. The stated CARES mission is to “realign and enhance VA health care to meet veterans’ needs now and into the future.” What I keep hearing from the VA is a need to close existing facilities to provide better care to our veterans; a promise to use any savings from CARES efficiencies to enhance VA healthcare in areas with a growing veterans population and expand coverage into currently underserved areas. Unfortunately, veterans in my State have no recourse if any expected cost savings don’t materialize, or are directed for another purpose. What assurances do we have that the Administration will request enough funding to cover the costs of expanding the coverage and enhancing care?

Response. While there are always budget constraints, the final CARES Plan will provide a systematic data-driven assessment of the capital requirements to meet the current and future needs of veterans. I am committed to developing capital funding requests that will provide the improvements and expansion of our infrastructure through the 5-year capital planning process. In many, perhaps most, cases the savings generated by CARES will require front end capital investments whose savings and revenues will not be realized until all the components of the realignment are in place and will occur over an extended timeframe. In addition, the capital requirements associated with realignments will receive the highest priority in developing these budget requests.

In this regard, we also note that S. 1156, marked up by the Senate Committee on Veterans’ Affairs on September 30, contains a provision (section 402) that would authorize VA to plan and carry out major construction as outlined in the final National CARES Plan. It would also authorize up to 5-year contracts for these CARES projects and the use of any combination of funds appropriated for CARES.

Question 3a. We know the final CARES plan may include the closure of nearly 6,000 beds—hundreds in Washington State. It is my understanding that the VA’s intention is to reopen these beds in other VA facilities or to contract out for the beds. But, I find virtually no mention of how this will be accomplished. Are you comfortable telling our veterans that their hospitals will be closed but hopefully beds will be found later?

Response. The draft National CARES Plan identifies the need for approximately 600 fewer acute care beds by 2022. These beds are spread among 20 VISN’s and do not significantly impact the future of any acute care facilities. The number of beds affected by proposed realignments total approximately 3,144. These are primarily Nursing Home, Domiciliary, and Long-Term Psychiatry beds. These beds will continue to be available either in other VAMC’s or through local contracts. If the proposed realignments are approved for the final National Plan, further study will be required to finalize the exact distribution; however, the majority of these beds are currently proposed for transfer to other VAMC’s.

Question 3b. How can the VA make the decision to close more than a hundred nursing home and psychiatric beds in Washington State without having examined the potential demand for such care?

Response. The proposed realignment maintains services to veterans and does not eliminate the nursing home and psychiatric beds to veterans. However, the forecasting models for Nursing Home, Domiciliary, and long term psychiatry that were available for the VISN market planning and the draft National CARES Plan required improvement to accurately represent the future needs of veterans. As a result, the demand for these beds was maintained at current capacity. This enabled the planning process to move forward while recognizing that final detailed planning would require projections of future demand. The planning models that will provide this information are under revision. If the proposals are approved, the revised planning models will be available to ensure that final implementation planning is based on the most accurate estimates of the expected needs of veterans.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JIM BUNNING TO THE
DEPARTMENT OF VETERANS AFFAIRS

Question 1. Dr. Roswell, would you please give me your reasons for proposing to close the Leestown Road Medical Center in Lexington? I particularly want to hear

what benefits you expect to come from that and what you plan to do to offset any losses there.

Response. The CARES Commission recommended that the Lexington-Leestown campus remain open, and that plans be developed to make the footprint of the Leestown campus smaller, making most of the campus available for disposition and/or enhanced use leasing. The benefits of remaining, on the Lexington Campus, but in modernized facilities, will alleviate any additional burden on Cooper Drive. While the mission of the Leestown Campus will remain unchanged VA will develop a master plan to provide for an appropriate sized footprint and consider enhanced use lease partnerships. At the same time, the master plan will provide an improved environment for care and maximize reuse potential of Lexington. As you know, these actions are consistent with the Secretary's May 7, 2004, decision for Lexington-Leestown to pursue opportunities to reduce the footprint of the Leestown campus.

Question 2. Dr. Roswell, the current VA hospital in Louisville is very old and the design is not suited to modern health care delivery. What other factors made you decide to study moving the hospital and what benefits do you expect to gain by a new partnership with the University?

Response. Due to the poor environment of care and overcrowding at the current Louisville VA Medical Center (VAMC), the CARES Commission recommended that VA study the feasibility of building a replacement VAMC for Louisville in proximity to the University of Louisville, including the possibility of a shared infrastructure with the medical school and the VA Regional Office (VARO). In his May 7 CARES decision, the Secretary decided to study the need for a replacement hospital for the Louisville VAMC, focusing on access to and quality of care as well as referral patterns with other regional medical centers, the potential for collaboration with the University of Louisville, and the collocation with the VARO. The study is expected to be completed in November 2005.

Question 3. Mr. Alvarez, what information are you looking for to decide whether to retain the existing Louisville facility or to build a new facility in cooperation with the University of Louisville?

Response. Due to the poor environment of care and overcrowding of the current medical center, the CARES Commission concurred with the Draft National CARES Plan proposal to study the feasibility of building a replacement medical center for the Louisville VAMC in proximity to the University of Louisville, including the possibility of shared infrastructure with the medical school and the VBA office. As you know, on May 7, 2004, the Secretary announced his acceptance of the Commission's recommendation and VA will undertake a comprehensive study of the feasibility, cost effectiveness and impact of replacing the Louisville VA Medical Center with a state-of-the-art medical center with a focus on access to and quality of care. Further, this comprehensive study will consider referral patterns from other regional medical centers, the potential for collaboration with the University of Louisville, and collocation with the Veterans Benefits Administration.

Question 4. Mr. Secretary, I am glad that the draft proposal recommends more clinics in Kentucky like we talked about earlier this year. I am not sure the final cares plan can predict all locations where clinics will be needed in the future. If the need is shown are you willing to consider and support building more clinics even if they are not in the final cares plan?

Response. The CARES Commission recommended that VA prioritize community-based outpatient clinics (CBOC's) under a national framework and continue to enhance access to care. In my May 7 CARES decision, I prioritized 156 of the CBOC's proposed in CARES for implementation by 2012 pending availability of resources and validation with the most current data available. This list reflects VA's priorities for planning based upon the most current information. As VA proceeds in implementing CARES and engages in future planning, the locations of these CBOC's may change, but the priorities will remain constant.

For example, VA currently has 11 CBOC's in Kentucky located in Prestonsburg, Whitesburg, Somerset, Morehead, Fort Knox, Dupont, Shively, Staniford, Bowling Green, Paducah, and Fort Campbell. Under the CARES plan, an additional 9 CBOC's will be implemented by 2012: Berea, Hopkins County, Perry County, London, Glasgow, Grayson County, Graves County, Davies County, and Carroll County. An additional CBOC in Morehead that was previously congressionally approved, but never implemented will be opened in 2005.

VA will enhance access to care in underserved areas with large numbers of veterans, enable overcrowded facilities to better serve veterans, and continues to support sharing with DOD. These principles will remain priorities even if management strategies to meet them evolve as new data and information become available.

Chairman SPECTER. Thank you very much, Mr. Secretary.

We will now proceed with a round for 5 minutes for each member.

Mr. Secretary, there has been considerable concern about the exclusion of Category 8, which would be veterans with non-service disabled or veterans who have income generally of less than \$23,000 a year. Do you foresee a relaxation there so that veterans who earn more than \$23,000 a year or some other combination of non-service connected disability would allow others to get the service? \$23,000 a year does not signify that a person could afford medical care.

Secretary PRINCIPI. Indeed, it does not, Mr. Chairman.

The answer to the question really depends upon the level of resources that the Department receives to provide care to, first and foremost, our core constituency, the men and women disabled in service; the poorest of the poor, who have few other options for health care; and third, those in need of specialized services like spinal cord injury and blind rehabilitation.

It is certainly my hope that, whether it be next year or the year after, we will be able to once again reopen enrollment to Priority 8 veterans, but our focus has been over the past year to ensure that those men and women, both in the past and returning from Iraq and Afghanistan today who are disabled in combat or in training accidents are able to access the VA health care system as well as the very, very poor, the pensioners, the people at the poverty line. I am sure that once we are able to do that, we are able to reduce our waiting list to zero, then we will certainly—I certainly will consider reopening it up to Priority 8s.

Chairman SPECTER. Mr. Secretary, what factors or what events—what do you think would have to occur before you would reopen Category 8 or at least make a modification to include more veterans?

Secretary PRINCIPI. Well, certainly, I think it depends directly on the level of appropriations that we receive from, you know, requested by the President and appropriated by the Congress and a recommendation from my undersecretary that we can reopen the doors to Category 8s, because we are able to meet the demands that are being placed upon the VA.

But I might say, Mr. Chairman, members of the committee, the demands are unprecedented. Categories 1 through 7 continue to grow dramatically in many parts of the country. More and more veterans are coming to us for care. A significant number are coming to us for prescription drugs, because they simply cannot get it, as we all know, in the private sector.

They have Medicare physicians. They are getting medical care, but they cannot get the prescription drugs, and they are coming to the VA in record numbers.

Chairman SPECTER. Mr. Secretary, there had been a preliminary staff review, which suggests that the real focus here is on psychiatric institutions like the one at Highland Drive in Pittsburgh, which is a facility for 1,000 people and is largely vacant, has only about 150 people, and some of those are homeless.

The treatment for psychiatric patients has now changed dramatically with drugs, with integration into the community. Is a major

thrust of the CARES project here the re-evaluation plan being directed toward psychiatric hospitals?

Secretary PRINCIPI. Acute psychiatric care is clearly considered in our plan. What we are doing in the VA is we are developing a new, long-term care psychiatric model to address the long-term psychiatric care, institutional care needs of our nation's veterans. But as you said, the focus in our Nation has been on community re-integration of the mentally ill back into the community, and we are able to do that because of revolutionary new drugs, but we also have to have the non-institutional care programs and the community support services available to care for these veterans and, you know, all Americans who are moved from mental institutions.

I believe that mental health is a very important core mission of the VA. It may not be as glamorous as some of the other things that are being done, but it is very, very core; very important: PTSD, substance abuse, chronic mental illness—

Chairman SPECTER. Mr. Secretary, let me interrupt you. I have got 16 seconds left.

Secretary PRINCIPI. Sure.

Chairman SPECTER. I want to ask one more question, and I am going to observe the red light.

You say you will accept the plan only in its entirety. Do you think that the law constrains you to take it all or none?

Secretary PRINCIPI. No, sir.

Chairman SPECTER. Or why would you not exercise some discretion?

Secretary PRINCIPI. I will exercise—

Chairman SPECTER. I will note the red light went on with the conclusion of the word discretion.

Secretary PRINCIPI. The law does not constrain me. I just did not want to be in a position to politicize this report by picking and choosing. I wanted to work closely after the commission submitted their report to me to address concerns that I might have, questions I might have, with regard to some of their recommendations and ask them to go back and to reassess it.

But I felt that politicizing this report would destroy its integrity and perhaps doom our entire effort. But I am not constrained by law.

Chairman SPECTER. Senator Nelson.

**OPENING STATEMENT OF HON. BILL NELSON, U.S. SENATOR
FROM FLORIDA**

Senator NELSON. Thank you, Mr. Chairman.

Mr. Secretary, as I described, in rural markets, we are having problems with veterans who have to drive long distances. Do you feel like we are serving our veterans in this area by placing the CBOC proposals in the Priority 2 category? It seems to me that that is a significant question, and I would be interested in what you think about that.

Secretary PRINCIPI. Well, as you know, Senator, over the past several years, the VA has moved very dramatically into outpatient care. Prior to the mid-1990's, if I am correct, Dr. Roswell, the VA had no freestanding community-based outpatient clinics, and it has been a dramatic change that today, we have close to 700 commu-

nity-based outpatient clinics; thereby, veterans in rural areas do not have to drive 4, 6 hours to a VA medical center to get care. They can access it much closer to their homes.

So we have literally gone from 0 to almost 700. This plan—and Dr. Roswell can comment—it calls for, I believe, another 48 community-based outpatient clinics. But we have to maintain balance. We have to preserve our inpatient care capability and our outpatient care. We cannot afford to go too far in one direction, because at some point in time, those veterans are going to need to get into inpatient care. That is why we have—Dr. Roswell, you may want to comment.

Dr. ROSWELL. Yes. Let me just add, Senator Nelson, that the Priority 1 CBOC's recommended in the national plan were those CBOC's where 7,000 or more veterans failed to meet the access criteria established in the plan. Unfortunately, the CBOC's proposed for your State did not meet those criteria. There were fewer than 7,000 veterans in those locations who would be served by a new CBOC. That is not to say, though, that they are taken out of the plan. A very important construct of the national plan that I forwarded to the CARES Commission was that the recommendations in the national plan augment what is in the existing plan. We still recognize all 262 CBOC's proposed in each of the VISN market plans as bona fide requests, and certainly, the ones from your State are included in that list of 262. But the national plan, of necessity, had to identify our highest priority, hence, those 48 included only those CBOC's where 7,000 or more veterans would now meet access standards.

Senator NELSON. Chairman Alvarez, is the CARES Commission considering at the present time changing the priority grouping for these CBOC proposals, or are you going with the initial recommendations, if you know?

Mr. ALVAREZ. At this time, we are not going along with anything. We are not sticking with any or making any changes. We are in the process of gathering information, and we are holding hearings around the country at this time. When we finish that, we will take all of the information that we have. I must add that we continually, as we go through the hearing and the data gathering process, continue to ask for more information.

But I can assure you that this is one area that we have a special interest in also. We have noted the large number of veterans who have to travel long distances for access to primary care, and of course, that is one of the charges I have given the members is to take a good look at that, understanding the Priority 1, Priority 2 categories, but look at everything very closely, so no, we are not following any special standard.

Senator NELSON. Mr. Secretary, as we were speaking about the creation of new veterans every day, are there any studies underway right now with respect to the wounded in terms of location as to where their future needs may be and how those special needs might be met as well as the current needs and the changing needs of areas? Perhaps Dr. Roswell would want to address that.

Dr. ROSWELL. Certainly, with the Secretary's leadership, we are working in an unprecedented manner with the Department of Defense to identify casualties coming out of Operation Iraqi Freedom.

To date, there have been 6,000 men and women who have been evacuated from that theater of operations. We are working very closely with DOD to track all of those.

Fortunately, the vast majority of them have non-life-threatening illnesses, and in fact, many of them may return to active duty. But where there are serious illnesses, it will certainly lead to future health care needs through the Department of Veterans Affairs and disability compensation benefits. We have established a very comprehensive program to identify those veterans and make sure they get their disability benefits, the services through the Department as well as the health care that is needed.

Secretary PRINCIPAL. We have full-time employees up at Walter Reed, at Bethesda, participating in the discharge planning process, so that we know when they leave Bethesda, Walter Reed, and go back to Omaha, wherever, that they do not fall through the cracks; that they are enrolled, and when they get to the VA, their name is in the computer. I think that is a very important step.

Senator NELSON. Thank you.

Thank you, Mr. Chairman.

Chairman SPECTER. Thank you very much, Senator Nelson.

Senator Hutchison.

Senator HUTCHISON. Thank you, Mr. Chairman.

Mr. Secretary, I think the most shocking thing that you have said here today is what the Chairman picked up on, and I did as well, that you do not intend to pick and choose among the recommendations. What I am concerned about is that while the committee will be charged with looking at the very best way to give the best service to veterans, it will be only the Secretary and the Department that could put the efficiencies and the budgetary issues and also the issues of where different services are given together to make a final decision.

So my question is: how are you going to put the overview on the commission findings so that you would be the one who could say certain areas could be addressed that perhaps the commission would not have the information to even put into the system?

Secretary PRINCIPAL. Once I receive a report and study it very, very carefully, it would be my intention to work closely with the members of the commission, the chairman of the commission, to address any issues that I believe need further refinement or perhaps need to be changed; that I have a question about or a concern about, and I will not approve the report until such time as I am convinced, in my own mind, that from both a local and a national perspective, it is correct.

I just did not believe it would be appropriate, once I had all of those questions asked and answered and my concerns addressed to start, you know, picking and choosing. I wanted to adopt this plan in its entirety to ensure that, from a national perspective, looking at all of the different markets, all of the different networks, that this plan promotes the delivery of health care, access and quality of health care across the nation. But I can assure you, Senator, that I will work very, very closely with the Chairman of the Committee to ensure that all the issues are addressed.

Senator HUTCHISON. Well, I am going to take it from that that you will provide the overview within the process before there is a final—

Secretary PRINCIPI. Most assuredly.

Senator HUTCHISON [continuing]. Plan adopted.

Secretary PRINCIPI. Most assuredly, Senator.

Senator HUTCHISON. Second, let me ask you, because I know two of my communities have asked this question, and I would assume it would probably be throughout the country, but my two communities would like to have some ability to offer help to make a hospital more effective. What would be the process for them to be able to do that? They have the hearings, but if they do not know exactly where you and your overview are going, they might not know what they could offer that would be helpful. So how are you going to accommodate that before the final, final decision to actually close a facility?

Secretary PRINCIPI. Well, I would certainly hope that communities would make those views known to the members of the commission when they testify; certainly submit proposals to the commission or to the undersecretary for any collaboration that might assist one way or the other in the disposition of what is going to happen at that facility and then certainly after the report is submitted can submit that to me.

So I would believe that right now, the commission is in the phase of holding hearings, gathering data and input from the communities, and community involvement and community impact is an important consideration for the commission. So I would suggest, Senator, that they make those views known to the commission, the commission staff here in Washington, and if there is any difficulty in getting that information to us, I would be more than happy to assist.

Senator HUTCHISON. Well, let me just ask—

Mr. ALVAREZ. May I?

Senator HUTCHISON. Yes.

Mr. ALVAREZ. In addition to what the Secretary just stated, what we are finding out is that there are a number of proposals that have come forth from the community affecting the plans. What we have found is that these people in the communities have already worked with the local VA people through the VISN director's office and have establishing relationships and are working on their portions. So I would offer that as another opportunity, because as a reviewing committee, we became aware of it and keep an eye out for it when it comes up.

But I think the bulk of the work can be initiated through the undersecretary.

Senator HUTCHISON. OK; thank you. I see my time is up. But there will be a second round?

Chairman SPECTER. No, we are going to have to move on, Senator Hutchison. Would you care to ask an additional question or two now?

Senator HUTCHISON. Well, yes. Let me just ask Mr. Alvarez: would you have in your purview also looking at the VISN recommendations that did not make it to the final draft plan?

Mr. ALVAREZ. Yes, Senator, we have access to all of that information.

Senator HUTCHISON. And will you look at those—

Mr. ALVAREZ. We will look at that plan.

Senator HUTCHISON [continuing]. As part of your decision-making?

Mr. ALVAREZ. We are asking questions not only about the national plan but also about the market plans that were submitted. So that is part of the—

Chairman SPECTER. Senator, there will be an additional round as to the other witnesses.

Senator HUTCHISON. Oh.

Chairman SPECTER. I was really referencing that as to Secretary Principi.

Senator HUTCHISON. Are the other witnesses going to speak and then have questions?

Chairman SPECTER. Secretary Roswell is not going to be offering an opening statement and is prepared to submit to questions.

Senator HUTCHISON. But Mr. Alvarez will?

Chairman SPECTER. Will, too. Mr. Alvarez will, too, so there will be another round.

Senator HUTCHISON. OK; well, let me just finish, then, with Mr. Principi one other question, and that is the one concern I have about a community coming forward with some suggestions is that you might have, in the back of your mind, a different use for the facility that the community could then say we will be able to provide, say, a private developer for an extra building with a lease-back or something that they might not know is in your mind. So will there be some process by which you could say we are looking for an opportunity to see what you could put forward in this realm, if it is different from what they are doing now?

Secretary PRINCIPI. Absolutely. Senator, this is a planning process that will result in a series of recommendations and from that point becomes a very critical stage of looking toward the implementation of this plan. I would highlight here that this is a 20-year plan and that some of the changes would take place in the first few years, but this is scheduled to be phased in over a 20-year period as the demographics of the veteran population change. So it is not going to happen all in year one or year two.

The second important point to mention for all members of the Committee is that it certainly is my intent not to sell this VA property, to excess it, to board it up. It is my intent and my hope that through the enhanced lease use authority that you have given us by statute that we can convert some of these properties that are underutilized into projects such as assisted living to meet the long-term care needs, the assisted living needs, of our nation's veterans or for other purposes that provide services to veterans.

So I expect that we will be maintaining this property, but we will be transforming it in many different ways. Of course, the community would play a major role in whatever decision is ultimately made.

Senator HUTCHISON. Thank you very much.

Thank you, Mr. Chairman.

Chairman SPECTER. Thank you, Senator Hutchison.

Senator Miller.

Senator MILLER. Mr. Secretary, have you received the input and participation, are you getting it that you hoped to get from the veterans' organizations?

Secretary PRINCIPI. Yes, we have, and we have really—

Senator MILLER. You have probably gotten more than you wanted?

Secretary PRINCIPI. Well, we have certainly tried to make that an important part of this process, and I think one of the criticisms early on, when that first phase was started, was that there was little input. When I changed this process around, I wanted to ensure, to the degree that we could, that the stakeholders had an input. Of course, a lot of that information and preliminary plans had to come to Washington for a national perspective, and some changes were made by the Under Secretary, and he can address those. But clearly, that was an important part.

Senator MILLER. I agree.

This is a question probably for Dr. Roswell. Explain to me how the medical facilities on the military installations, how are they worked into this process exactly.

Dr. ROSWELL. In the formulation of the national plan, we had three representatives from the Department of Defense who worked very directly with us and considered a large number of potential collaborations. In fact, upwards of 70 different potential collaborations between VA and DOD were considered. Twenty-one were identified as high priority in the national plan and went forward as projects to be pursued in collaboration with the Department of Defense.

Senator MILLER. I cannot help but wonder, though, what would happen if BRAC comes along and closes those that you have worked into that.

Dr. ROSWELL. Well, certainly, that is a concern that we have addressed. That is why we have asked for DOD input. Obviously, no one can foretell what the next round of BRAC will bring. But I think the collaboration and the highest and best use of Government facilities, be they VA or DOD, to better serve all Americans, certainly, is a laudable use of Government resources that would surely be considered by a BRAC process in the future.

Secretary PRINCIPI. I think there is a growing realization, Senator, that the military and the VA need each other. You know, we are two very large health care systems in this country, the largest direct health care providers in America, and we are both national resources, in my opinion, to the American people. By working together, we can provide more care to more people in a more cost-effective manner. That is why sharing makes a great deal of sense. We are doing that at Kirkland in Albuquerque. We are doing it in Nevada. We are doing it in Alaska. We are doing it out at Tripler in Hawaii. Across the country, we are finding the military and the VA are working closer together than ever before. I think that is good news for military people, for veterans and for the American people.

Senator MILLER. I share that belief.

Thank you.

Chairman SPECTER. Thank you, Senator Miller.

Chairman SPECTER. We are now going to have another round with Chairman Alvarez and Secretary Roswell. We had intended the first round to be on Secretary Principi, but we are flexible, and when the questions have gone to the other witnesses, that is fine.

Dr. Roswell is the deputy undersecretary and, in that capacity, heads the Veterans Health Administration. He has an excellent background, having directed VA's health care networks for Florida and Puerto Rico. He had served in Birmingham, Alabama and Oklahoma City. He is a 1975 graduate of the University of Oklahoma School of Medicine. I would like to say, on a parenthetical personal note, I went to the University of Oklahoma for a year myself at the start of my college career. I notice that Senator Nelson is not going to touch Oklahoma and Nebraska, at least at this point.

[Laughter.]

Chairman SPECTER. Chairman Alvarez is a member of the Bar of the District of Columbia. He served as deputy administrator of the Veterans Administration from 1982 to 1986 and deputy director of the Peace Corps from 1981 to 1982. But I think his most remarkable public service occurred on August 5, 1964, when, as a young lieutenant, junior grade, he was the first American pilot shot down over North Vietnam; 8½ years in a prisoner of war camp in North Vietnam, as described in his book, *Chained Eagle*, the circumstances relating to that. For those who have read the book, it is very inspirational. So we thank you for your great service, Chairman Alvarez, taking on this job. We will start a second round of questions as to both Dr. Roswell and Chairman Alvarez.

Dr. Roswell, as I stated, is only responding to questions; does not have an opening statement. If you would care to make an opening statement, Chairman Alvarez, we would be pleased to hear it.

STATEMENT OF EVERETT ALVAREZ, JR., CHAIRMAN, CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES) COMMISSION, U.S. DEPARTMENT OF VETERANS AFFAIRS, WASHINGTON, D.C.

Mr. ALVAREZ. Thank you, Mr. Chairman. I have submitted a statement for the record, and if it is all right with you, I will just summarize it.

Chairman SPECTER. Fine. The full statement will be made a part of the record, and we will welcome your summary.

Mr. ALVAREZ. Thank you.

As stated in the CARES Commission charter, Secretary Principi established our commission in December of 2002 to bring an objective and external perspective to the CARES process. The parameters set for the 16-member commission that we have are straightforward. First, we are to review the proposed realignment and allocation of capital assets described in the undersecretary's draft national CARES plan in order to determine whether the proposals reasonably assess and meet the demand for veteran health care over the next 20 years, with the understanding that the goal is to enhance VA's health care services. Then, we will make specific recommendations to the Secretary.

I want to state that our mission is not to provide a 'de novo' review of the VA medical system or to rebuild the proposed plan. In

accordance with our charter, we may accept, modify or reject the recommendations in the draft national CARES plan. We will provide our rationale for any positions that we take. Further, in making these recommendations, we will consider information that we are gaining from involved parties that speak at our meetings and through our nationwide site visits; written comments from interested parties and formal public hearings that we currently are holding.

By dividing into groups, our commission was able to visit 59 VA facilities in July, and we will have visited nine more by the end of this month for a total of 68 site visits. These informal tours through VA facilities and the geographic areas they serve have included meetings and conversations with many veterans, individuals inside the VA family and local community leaders. In addition, currently, we have completed over half of our 36 formal public hearings, with the last one scheduled for October 3. The selection of the sites for all of the public hearings was made with careful consideration of many factors, and this deliberative process included coordination with many of the VISN staffs and their directors, reviewing market plans and taking into account the public access to the hearings.

The locations were selected to provide access to concerned individuals from all markets covered at each hearing. Where appropriate and available, we are also providing video feeds from the hearings to medical centers in some locations to ensure easier access for attendees who might otherwise not be able to personally view the proceedings.

Thousands of individuals have attended these public hearings so far, and we have heard from the local population mostly impacted by the draft plan. Oral testimony has usually been sought from local veteran service organizations, employee organizations, academic affiliates, organizations with collaborative relationships and involved local elected officials. We have also welcomed Members of Congress who have either submitted their views personally or through written statements, and we have also received, as of this week, comments from over 11,500 individuals.

Let me conclude by thanking you for the opportunity to advise you of the work of our commission. I believe it is a deep honor and a responsibility I take very seriously to serve as the chairman of the CARES Commission, and I hope that our counsel will assist Secretary Principi and the Department of Veterans Affairs in its goal to effectively realign and allocate VA's capital assets to meet the demand for health care services for our well-deserving veterans over the next 20 years and beyond.

Thank you very much.

[The prepared statement of Mr. Alvarez follows:]

PREPARED STATEMENT OF EVERETT ALVAREZ, JR., CHAIRMAN, CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES) COMMISSION, U.S. DEPARTMENT OF VETERANS AFFAIRS

As you know, and as stated in the CARES Commission Charter, Secretary Principi established the CARES Commission in December 2002 to bring an objective and external perspective to the CARES process. The parameters set for the 16-member Commission are straightforward: the Commission is, first, to review the proposed realignment and allocation of capital assets described in the Under Secretary's Draft National CARES Plan in order to determine whether the proposals

reasonably assess and meet the demand for veterans' health care over the next 20 years, with the understanding that the goal is to enhance VA's health care services. We will then make specific recommendations to the Secretary.

At the first of our monthly meetings, in February, the Secretary asked the Commission to examine the Draft Plan with a critical and independent eye. He also asked us to report to him on the validity of the opportunities identified in the Plan for improving VA's ability to provide quality healthcare for veterans by effective deployment of physical resources. We intend to fulfill this responsibility.

Our mission is not to provide a 'de novo' review of the VA medical system or to rebuild the proposed Plan. In accordance with the Commission Charter, the Commission may accept, modify or reject the recommendations in the Draft National CARES Plan. We will provide our rationale for any positions we will take. Further, in making these recommendations, we will consider information gained from involved parties speaking at our meetings and through nationwide site visits, written comments from interested parties and formal public hearings.

We will also rely on our own experiences. Over time, and in conversations with my colleagues, we have recognized and agreed that, in appointing the Commissioners, the Secretary identified and appointed individuals whose qualifications, taken together, supply a sound basis for fulfilling this mission. The commissioners come from all walks of life—doctors and nurses, medical and nursing school professors and deans, health care professionals, members of veterans service organizations, former VA officials, business managers and leaders in their communities. We also have learned to recognize and depend upon the special backgrounds and experiences each of us brings to the Commission, and have noted each other's deep sense of commitment to the Commission's unique mission to benefit America's veterans.

Before we can make our recommendations to the Secretary, as I stated earlier, we will consider information gained through our meetings, nation-wide site visits, written comments from interested parties and formal public hearings.

At our monthly meetings, we have heard from and questioned representatives from the CARES office and the contractors who developed the underlying model to the Draft Plan. We also have heard from others, from within and outside VA, such as representatives from Veterans Service Organizations, employee organizations, medical affiliates, experts in modeling, enhanced use opportunities, and Federal property management and from the GAO.

By dividing into groups, the Commission was able to visit VA facilities in 59 locations in July and will have visited 9 more by the end of this month, for a total of 68 site visits. These informal tours through VA facilities and the geographic areas they serve have included meetings and conversations with many veterans, individuals inside the VA family and local community leaders.

In addition, we have completed over half of our 36 formal public hearings, with the last one scheduled for October 3. The selection of the sites for all of the public hearings was made with careful consideration of many factors. This deliberative process included coordinating with the many Veterans Integrated Service Networks, or VISN's, reviewing market plans, and taking into account public access. The locations were selected to provide access to concerned individuals from all markets covered at each hearing. Where appropriate and available, we also are providing video feeds from the hearings to medical centers in some locations to ensure easier access for attendees who might otherwise not be able to view the proceedings.

The CARES Commission's public hearings are formal proceedings where invited witnesses submit written testimony and answer the Commissioners' questions. Thousands of individuals have attended these public hearings, where we heard from the local population most impacted by the Draft Plan. Oral testimony has been sought from local Veterans Service Organizations, employee organizations, academic affiliates, organizations with collaborative relationships and involved local elected officials. We have also welcomed Members of Congress, who have either submitted their views personally or through written statements. We also have received, as of the beginning of this week, comments from 11,500 individuals.

Before we begin our deliberations, however, we will hold, in this very room, our first National Meeting since the Draft National CARES Plan was issued where we will hear from parties outside of the Department of Veterans Affairs. This meeting is scheduled for Tuesday, October 7. We are inviting, from both the Senate and House of Representatives, the Chairmen and Ranking Members from the Veterans Affairs Committees and Appropriations VA, HUD and Independent Agencies subcommittees. We also are inviting leadership from Veterans Service Organizations, the Department of Defense, national Veterans Affairs employee organizations and national medical and nursing affiliate's organizations. As a final step in the Commission's information gathering process, and as we prepare to begin formal deliberations, we have asked these leaders to provide a national perspective on the CARES

process and the Draft National CARES Plan to the entire Commission. We believe hearing their opinions provides an essential and valuable contribution to the Commission. The meeting is scheduled to begin at 8:30 a.m.

Let me conclude by thanking you for this opportunity to advise you of the work of the Commission. I believe it is a deep honor, and a responsibility I take very seriously, to serve as the CARES Commission Chairman. I hope our counsel will assist Secretary Principi and the Department of Veterans Affairs in its goal to effectively realign and allocate VA's capital assets to meet the demand for health care services for our well-deserving veterans over the next 20 years. Thank you.

Chairman SPECTER. We will now proceed to 5-minute rounds for each of the members.

Dr. Roswell, are you in a position to give categorical assurance to the veterans in the Pittsburgh vicinity that before the Highland Drive facility is closed that there will be a replacement facility opened.

Dr. ROSWELL. I cannot give a categorical assurance, because—

Chairman SPECTER. How about a plain assurance.

Dr. ROSWELL. Well, obviously, the University Drive division, where those patients are planned to be relocated, will require some structural renovations that will be dependent upon construction appropriations being available to the Department, but I can give you an absolute assurance that we will not separate any veteran from care that is currently being received unnecessarily.

Chairman SPECTER. Not separate them unnecessarily, you say?

Dr. ROSWELL. In other words, we will not—

Chairman SPECTER. In what context did you use the word unnecessarily?

Dr. ROSWELL. We will be sure that all care provided to veterans is continued throughout this process.

Chairman SPECTER. Well, you do not know about the appropriations for the other facilities; OK, you do know, you do have the power to control not closing down Highland Drive until the replacements are there.

Dr. ROSWELL. That is correct, and that would be the intent. The Secretary spoke of VISN 12. We have had a situation where patients could be relocated to an existing facility without the need for new construction, although new construction was planned as a further enhancement of that campus. In those situations, patients were moved.

Chairman SPECTER. Well, OK, but what you are saying is that Highland Drive is not going to be closed until you can accommodate the veterans in the area at the new facility.

Dr. ROSWELL. That is correct.

Chairman SPECTER. OK. Moving on to Butler and Erie and Altoona, Pennsylvania is a fairly popular State on the hit list. Does that have anything to do with my being Chairman?

Dr. ROSWELL. No, sir, it does not.

Chairman SPECTER. OK; I am advised that the network director did not recommend the changes as to Butler, Erie or Altoona, and I am also advised that it is OK for me to say that, not revealing any confidences in making that disclosure. It is important to know things; it is also important—not important; indispensable to maintain confidences, but we are not disclosing any confidences.

Now, as to Butler, there seems to be a view that because it is small, it ought to be closed. I hope you will not make that distinc-

tion, because there are many facilities which are small. I go back to my early days in the State of Kansas where everything is small. It might even apply to Nebraska. What is the thinking, Dr. Roswell, on closing someplace because it is small?

Dr. ROSWELL. Well, our first priority is to make sure that we provide world-class care to veterans and to do that to an increasing number of veterans in the years ahead. Let me point out that the CARES plan actually will enhance our ability to provide services to—

Chairman SPECTER. Dr. Roswell, I have got two more questions in a minute and 44 seconds.

Dr. ROSWELL. With regard to Butler, there are only a very small number of acute beds, just 30 miles away from a world-class facility at Pittsburgh. That is our recommendation, to move that acute inpatient care there. But we would preserve the nursing home care and the outpatient care that currently is provided with very high quality at Butler.

Chairman SPECTER. Let me urge you not to make decisions on the basis of size smallness, and let me urge you to travel Route 8 from Butler to Pittsburgh before you make the final decision.

As to Erie, the plan is to cease inpatient surgical services, and my review and the information I have pretty conclusively is that the inpatient surgical services are very good, notwithstanding the contention that because they are limited, they may lose their skills. What is your thinking on Erie?

Dr. ROSWELL. Actually, our recommendation in the national plan is to discontinue acute inpatient surgery but to maintain a surgical observation unit and allow the staff to continue to perform outpatient surgeries.

Chairman SPECTER. Why the limitation?

Dr. ROSWELL. Because the average daily census in 2002 at Erie on the surgical service was three patients. We do not believe that provides sufficient numbers of patients to justify or to provide the high quality of care that is required of our patients not only by the surgeon but by the entire perioperative team.

Chairman SPECTER. Well, I hear those surgeons have access to other work to keep their skills sharp.

My last question in the eight remaining seconds is as to Altoona, you talk about a critical access hospital. What does that mean?

Dr. ROSWELL. A critical access hospital is a hospital that basically recognizes that small hospitals are needed, just as you have said, Mr. Chairman, in certain locations. The inherent danger with quality in a small hospital is if the staff are tempted to provide care beyond their capability. In many cases, we have part-time physicians who maintain their skills, but let me point out that in situations such as Erie, the nursing staff, the postoperative staff, are generally full-time VA employees, and they need to maintain their skills as well to assure that quality care is continued. We believe we can do that on an outpatient basis, but on an inpatient basis, we have to maintain the integrity of the entire staff.

A critical access hospital would not normally provide surgical care other than limited outpatient care. It would be designed to provide inpatient care for less-complicated inpatient requirements that normally could be managed definitively within a 96-hour pe-

riod of admission. For patients who require inpatient surgical care or more intensive inpatient care, including ICU stays, the recommendation would be to stabilize those patients and transfer them to a world-class tertiary facility such as the one in Pittsburgh.

Chairman SPECTER. Senator Hutchison. Pardon me, Senator Nelson.

Senator NELSON. Thank you, Mr. Chairman.

With respect to changing acute care hospitals to critical access hospitals, it is my understanding that the VA uses the Medicare definition generally. But in the case of the Cheyenne Medical Center, that apparently is not the case, because the average stay there is considerably longer than in the case of a critical access hospital. But, yet, you want to switch it to that.

It has a great impact on Nebraskans. One thousand Nebraskans utilize that center. In the past fiscal year, there were 3,578 visits by 1,000 Nebraskans for acute care at about 130 hours above the 96-hour threshold. Yet, you are in the process of apparently recommending changing that category. Can you explain to me why that is the case and, also, how that is going to improve care for those Nebraskans and others who use the hospital?

Dr. ROSWELL. Well, ultimately, Senator, we believe that the veterans in western Nebraska are entitled to the same standard of care as veterans are anywhere in the nation, and we want to make sure that that care is high-quality care and accessible. Sometimes, that is not possible because of the sparse populations.

In the case of the Cheyenne, Wyoming facility, the level of surgical care is somewhat limited, but the level of expertise, the imaging support, the technology support for the hospital in Cheyenne is less comprehensive than it is, for example, in Denver. We still believe that that hospital serves a very—

Senator NELSON. It is a long way to Denver.

Dr. ROSWELL. It certainly is. There is no question about that.

But we believe that we have to assure that patients who receive care at that facility receive the very best possible care we can provide. The recommendation to make it a critical access-like hospital would be to limit complex surgical care and to attempt to reduce stays on average to 96 hours.

Senator NELSON. Well, I applaud the effort at trying to get quality care, because the last thing we want is a reduction in quality care. But the access issue and the ability of people to be able to get that access continues to be in doubt. Would you, for example, be able to certify the hospital, which is not a VA hospital but could become an approved hospital, in Scottsbluff, which is a full-service hospital with regard to everything? I mean, I think we have to have a plan other than saying go to Denver, and I appreciate the fact that Mr. Alvarez is picking up on where I am going, because I think it is not going to be unique to Nebraska; obviously, it is going to have implications for Texas. The whole VISN 23, a very rural area, is going to be affected by very similar decisions.

Dr. ROSWELL. I certainly agree with the premise, and let me point out that in the national CARES plan, reliance upon contract hospitalization, access to tertiary services contracted locally in the community, is a key feature, and it is a current deviation from VA's

existing policy. With me today is the acting director of our national CARES program office, Mr. Jay Halpern, and he may wish to address that further.

Mr. HALPERN. Senator, we are absolutely committed to maintaining services that are accessible. In areas where there are those tertiary capabilities that meet those standards, we would want to contract with them. In addition, we will be developing our own critical access hospital policy. Ninety-six hours right now is what Medicare uses. I do not know that we are fixed to that length of stay. We have to develop our own policy that makes sense for us. But certainly, that is the intent.

Senator NELSON. Well, can you give me a categorical assurance that before people are told in Western Nebraska that they can no longer go to the Cheyenne Medical Center because of the change you will have a contract in place with another facility in closer proximity to those veterans? Because I think that is the question, and that has to be the goal.

Dr. ROSWELL. It is unequivocally the goal, that we enhance access to services, including outpatient care, inpatient care, surgical care, and all types of care that veterans might need, including those in Western Nebraska. We will do everything that we possibly can. That is as close of an assurance as I can give you.

Senator NELSON. It is not quite categorical, but it is moving in that direction.

Dr. ROSWELL. Thank you.

Senator NELSON. Thank you.

Thank you, Mr. Chairman.

Chairman SPECTER. Thank you, Senator Nelson.

Senator Hutchison.

Senator HUTCHISON. Thank you, Mr. Chairman.

Let me just ask Dr. Roswell: the VA estimates that the number of veterans most in need of long-term care, 85 years of age and older, will more than double to about 1.3 million in 2012. Yet, I am told that the CARES planning process did not take into account the long-term care and outpatient mental health needs projections. So how are you going to care for those people that you are projecting to have such an increase in population?

Dr. ROSWELL. Well, actually, Senator, we believe that the population over 85 will triple by 2012, so your point is extremely well-taken. We are very concerned about providing long-term care to older veterans, and we will have a substantial burden. We have preserved the current long-term care capacity in the national CARES plan. We believe, however, we need to carefully examine our long-term care policies to determine what mix between institutional and non-institutional care will be required to meet the future demand.

We also have been criticized, and understandably so, for proposing to close hospitals when we, in fact, might need those facilities to provide nursing home care to older veterans if institutional care becomes a requirement. We have learned, through very painful experiences, that when you convert a 50-year or older hospital which was designed for hospital care a half-century ago to a nursing home, you wind up with a substandard nursing home, and the

cost of such conversion is approximately twice the cost of new construction.

So we anticipate that, in fact, when we are able to further determine the definitive long-term care policy, we may need additional long-term care beds. But we believe veterans deserve the best long-term care facilities, and that would be new construction in lieu of converting a 50-year-old hospital to inadequately meet the long-term care needs.

Senator HUTCHISON. Thank you, Mr. Chairman. I asked my other question of Mr. Alvarez earlier, and I appreciate that opportunity. Thank you.

Chairman SPECTER. Well, I will return to the questions that I asked you that really could not be answered in the course of the 8 seconds that we had left, and we will be submitting some additional questions for the record. But when we are talking about the medical center in Erie, and we are talking about enough cases to have adequate competency, you cannot maintain sharp surgical care if a surgeon does not have enough cases. But it is my understanding that although the surgeons would have only a few cases at the VA facility, they would have other practices privately where they are maintaining their skills, so that there is really no reason to close Erie because the doctors do not have adequate surgical skills. Is that not correct?

Dr. ROSWELL. The premise that you presented is a correct premise, that the surgeons, in fact, may maintain their surgical skills by practicing in venues other than the VA facility. However, just as important if not more important is the anesthesia staff, the post-anesthesia recovery staff, the surgical nursing care that is provided within the first 24 hours postoperative and then the continuing surgical care that is provided by the nursing staff.

In those professions, not physicians but still valuable members of the health care team, nursing personnel need to maintain their skills with regard to surgical care and postoperative surgical management, and it becomes more difficult to maintain that skill set in that population of professionals.

Chairman SPECTER. Well, Dr. Roswell, have you analyzed those collateral skills and come to the conclusion that they are not sufficiently active to maintain those skills.

Dr. ROSWELL. We have looked at that both within the Department; we have looked at that through our National Surgical Quality Improvement Program. We have looked at the results of the leapfrog group, which is—

Chairman SPECTER. How about at Erie?

Dr. ROSWELL. At Erie, I have not personally or specifically looked at that.

Chairman SPECTER. Well, have your subordinates.

Dr. ROSWELL. Again, let me ask Mr. Halpern to address the situation at Erie.

Chairman SPECTER. Mr. Halpern, we had not expected you to testify, so we have not extolled your virtues. But let the record show that you are the acting director of CARES; have been that since December 2002; that you have 35 years in the Federal Government in a variety of health care capacities, and we will include your resume in the record. It is very distinguished.

Mr. HALPERN. That is very fine. Thank you, Senator.

Chairman SPECTER. Now, you may answer, now that you have been accredited.

Mr. HALPERN. What I would add to Dr. Roswell's comment is that it is not just about today's practice of medicine and practice of surgery. It is looking into the future. It is very hard for a small facility to acquire the technology, the diagnostic and interventional technologies that are increasingly a part of modern-day surgery. So it is very difficult for staff, in fact, to be skilled in those particular areas, particularly support staff, the technical staff. We have not specifically site-visited and assessed Erie.

Chairman SPECTER. Well, I would like you to take a look at that, because the backup facilities identified by Dr. Roswell have been functioning there for some time, and we can make a determination as to whether they are able to maintain their skill level. But I think before you can make a determination for closing a facility, you really have to individualize your analysis, just take a look at the specific facility, because we will. This Committee will. So we are going to be asking you the hard questions as to what the facts are upon which you base your conclusion that there are insufficient skill levels. So I would ask you to take a look at Erie.

Dr. ROSWELL. Mr. Chairman, I understand your concern. I will share a—

Chairman SPECTER. It is not only a concern for Erie. I have not had a chance to go to all of the other facilities that are on the list, but all of these other Senators will.

Go ahead, sir.

Dr. ROSWELL. I just want to say that I have met with the VISN director from VISN 4 and the facility directors. We have discussed this in great detail. I sat across from the table, much closer than you and I are, with the director of one of the smaller facilities, and I said yes or no, if you had a serious problem, would you want to get acute care in your hospital? And the answer was no.

Chairman SPECTER. How is it that you can get yes or no answers, and I cannot?

[Laughter.]

Chairman SPECTER. Well, let us go on to Altoona. In more than 8 seconds, tell me what a critical access hospital is.

Dr. ROSWELL. First of all, let me point out that Altoona has a fairly dynamic work load right now. The recommendation in Altoona is, and the projections are, that by the year 2012 and beyond, the demand for acute inpatient care at that location will decline to the point where it really may not be feasible any longer to maintain an acute tertiary inpatient—

Chairman SPECTER. You are projecting to when?

Dr. ROSWELL. 2012, so the recommendation in the national CARES plan would actually maintain Altoona—

Chairman SPECTER. 2012? How do you project to 2012, Dr. Roswell?

Dr. ROSWELL. We took the 2000—

Chairman SPECTER. I talked about that with Strom about 20 years ago when he could not do that.

Dr. ROSWELL. Well, it is difficult. There is no question about it. But we are using the very best health care actuary in the nation,

in the world, for that matter, to help us project. We are extrapolating the veteran population. We look at the demand for care, the types of problems treated, and we actually come up with what we believe are fairly accurate projections that not only look into the future but have been validated by back-testing. We believe that they are, in fact, as accurate as we possibly can be.

As the Secretary pointed out, this is a 20-year plan that looks at a comprehensive set of resources that must be in place for veterans in the decades ahead, and it is imperative that we act now to be able to address those needs in the future.

We may be wrong, though. In the case of Altoona, if we do not see the decline in the acute inpatient work load, it will not convert to a critical access hospital.

Chairman SPECTER. Well, we want to help you not be wrong, especially as to Altoona. When you say Altoona is dynamic, it is a growing area. It is an area on the move. I will take a look at your projections and how you figure it out. But from what I see on the ground, Altoona is growing. It is not contracting.

Dr. ROSWELL. Well, again, this would be a recommendation to monitor the actual inpatient census, but we anticipate that sometime around 2010, 2012, the census would begin to decline, which would then, at that time and only at that time, require us to re-evaluate the mission of the Altoona VA Medical Center. We will be happy to monitor it concurrently with you and certainly will take no actions to reduce the scope of services at Altoona unless we actually observe, realize that decline in inpatient work load.

Chairman SPECTER. Well, all right; that is a good assurance, if you are not going to alter the available services at Altoona until you see that actual decline. That is not based on a projection; that is based on hard facts at hand.

Dr. ROSWELL. Exactly.

Chairman SPECTER. I also want to thank you, gentlemen, for coming in today. There is a lot of interest in this subject matter across the country, and that is reflected by a lot of interest on Capitol Hill. I know you men and the Veterans Administration generally are committed to veterans' care, and I conclude with the same admonition on skepticism that I began with: wherever I travel extensively in my State and beyond, veterans are concerned about the adequacy of the budget. So, starting there and the budget constraints, there is just an inevitable feeling that changes are being made with regard for the continuation of service.

I think your testimony here is solid on those assurances, and we are going to have to back it up, and it is important for the veterans to know that there will be Congressional oversight and Congressional analysis on what you are doing.

Thank you all very much, and that concludes our hearing.
[Whereupon, at 3:30 p.m., the committee adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR
FROM WASHINGTON STATE

Chairman Specter, I want to thank you for convening the Committee, and I want to welcome Secretary Principi and Chairman Alvarez.

As we all know—under the CARES initiative—the Department of Veterans Affairs asked its regional offices to study the health care needs of local veterans and to develop a plan to meet those needs.

I support the idea behind CARES—to provide a realignment of veterans' healthcare services that will enhance care for those who fought so bravely for our country.

However, as this process has moved forward, there have been some troubling revelations, and it appears that Chairman Alvarez has an unenviable job. It seems CARES is driven more by meeting budget targets than by meeting the healthcare needs of our veterans. Local experts in my region—which covers Washington, Oregon, Idaho and Alaska—submitted a plan several months ago that showed dramatic enrollment growth, and significant gaps in areas like long term care, primary care and specialty care. The VA sat on this report for several months. Then, just 8 days before the scheduled release of the national report, the VA called up leaders at more than two dozen facilities—including three in Washington State—with some shocking news. The VA said that it didn't like their recommendations. VA headquarters then ordered these regional leaders to include a new and troubling recommendation—closing these VA facilities. The next day, I sent Secretary Principi a letter outlining my objections to the VA's interference with the regional market plan and expressing my strong opposition to closing any of the three Washington VA facilities.

The CARES process is supposed to provide an objective, external perspective as the VA works to meet the increasing demand for veterans healthcare. Veterans deserve more from the VA.

Since that time, Secretary Principi personally pledged to me that one of the Washington State facilities—American Lake in Tacoma, Washington would not be closed.

I appreciate the Secretary's admission that the possible closure of American Lake was a tremendously flawed proposal. Questions remain at the other two facilities in my state—in Vancouver and Walla Walla—as well as other facilities around the country.

In Vancouver, instead of the creative community-based partnerships that were proposed, the VA will potentially shut this facility in the fastest growing area of Metropolitan Portland. In fact, patient numbers have risen 17 percent this year—more than three times as fast as usual—at the combined Portland / Vancouver medical center.

The city of Vancouver, Clark County and the VA have been working for years to create an enhanced use facility that would compliment the services at the Vancouver facility. Now, only a few months from issuing construction bonds, this plan may be in jeopardy.

In Walla Walla, veterans may lose a facility that was shifting to long term care and some other services may be contracted out. The Walla Walla VA Medical Center is also one of the largest employers in the community and serves a veterans population of approximately 69,000.

Closure of the Walla Walla facility would leave area veterans 180 miles from the Spokane VA Medical Center.

And let's not forget that there is a Federal law—on the books since 1987—that prohibits changing the mission of the Veterans Administration Medical Center in Walla Walla.

Veterans in Washington State and across the country are having a terrible time getting the care they need, but instead of improving services, the VA is exploring closing facilities.

Another troubling aspect of the CARES process is the apparent disregard of veterans long-term care needs.

While Secretary Principi has stated that CARES includes a “commitment to long term care,” the model used to project demand did not include long term care or mental health care.

The VA said that the modeling for such care “needed more work” and that “the Department cannot wait on perfection.” Yet, the VA readily acknowledges that the number of veterans age 75 and older will increase from 4 million to 4.5 million by 2010. And, both the VA and the GAO estimate that the veterans population most in need of nursing home care—veterans 85 years old or older—is expected to triple to over 1.3 million by 2012 and remain at that level through 2023. Clearly we’ve got to do more—not less—to meet this growing need.

A major function of the Vancouver and Walla Walla facilities is long term care, and I’m going to continue to speak up for the veterans I represent. They deserve better than the treatment they’re getting from this Administration.

So Mr. Chairman, I will have more questions for the Secretary to answer this afternoon, just as I did when the VA’s General Counsel testified before this committee.

I fear that the CARES process is losing its legitimacy, and the good work Chairman Alvarez set out to accomplish is being driven by budgetary issues within the VA.

Mr. Chairman, I believe this Committee must increase its oversight. We have to ensure that CARES and the work of the Department and the Commission are transparent and accessible to veterans. The VA’s stealth effort to potentially close facilities in Washington State—despite the regional recommendations and a lack of long-term care data—is a sign that the CARES process is a growing problem for the VA and the Congress. Our veterans deserve better, and I’m going to hold this Administration responsible for the way it’s treating the veterans of Washington State.

PREPARED STATEMENT OF HON. JIM BUNNING, U.S. SENATOR FROM KENTUCKY

Thank you, Mr. Chairman. Kentucky will be heavily affected by the CARES Process. The draft proposal now being considered by the CARES Commission proposes to close a medical center in Lexington and relocate the Louisville Medical Center. I am very concerned about that and so are the veterans in Kentucky.

I certainly support new and improved facilities that improve VA’s ability to provide timely and quality health care. But any reductions or closures of facilities must be accompanied with other means to ensure no veteran is unable to get the help he or she needs. Mr. Secretary, Dr. Roswell, and Mr. Alvarez, I am counting on you to make proposals that are good for all our veterans.

At hearings earlier this year I talked about the benefits of partnerships with university medical schools. The medical centers in Lexington and Louisville have strong partnerships with the universities there. I support those partnerships and encourage you to strengthen those as you move forward. The draft proposal does that and I hope that remains in the final plan.

In Lexington there is not much space to expand around the medical center at the University of Kentucky. Many veterans have trouble going there because of parking. While those issues are addressed in the draft proposal, I believe very serious thought and planning needs to go into any changes in Lexington to ensure enough capacity is added at the hospital and veterans are able to get there easily.

The draft proposal recommends a stronger partnership with the University of Louisville, including a possible new facility adjacent to University hospital. I support stronger ties with the University and an upgrading or replacing the current medical center should be a priority. The Louisville Medical Center is the oldest in the region. The University of Louisville is eager to work with VA to develop an innovative proposal to provide better facilities and more access to the University’s resources.

I strongly support that. If VA decides to move the current hospital, I hope any new facility is built in partnership with the University of Louisville.

Mr. Secretary, earlier this year you and I talked about VA clinics in Kentucky. I am very pleased that the draft proposal contains several new clinics in the eastern half of the Commonwealth. Veterans in Kentucky love the clinics and want more of them. I hope the final proposal adds even more clinics throughout the Commonwealth, especially in western Kentucky and places like Owensboro where the com-

munity has stepped forward and offered to help by providing facilities and other resources.

One final point I want to make is that I encourage VA to work with the Army to share resources at Fort Knox and Fort Campbell. Many veterans live around those bases and it only makes sense that the two departments should work together in those areas.

Again, I want what is best for our veterans. I urge the VA to be careful in making any recommendations and to provide Congress and the public strong evidence for making any changes. Thank you for coming today. I look forward to hearing your answers to my questions.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR
HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee: The Secretary has described the reasons for CARES and the process utilized to develop the market plans and the Draft National CARES Plan. My statement today will focus on the Draft National CARES Plan itself.

In preparing the Draft National Plan, VA developed demographic projections through the year 2022, conducted a comprehensive capital inventory, assessed usage and vacant space, conducted a clinical inventory of programs offered at all sites, and developed access standards for the use of all VA facilities in evaluating accessibility of their services. The Draft National Plan is based on national themes such as improving access to high quality health care services, ensuring outpatient capacity, enhancing access to special disability programs, and prioritizing the capital infrastructure needed to support delivery of high quality health care into the future.

The VISN's market plans contain the results of thousands of decisions regarding how outpatient and inpatient demand will be managed, i.e., whether space will be leased, renovated, or constructed, or whether community contracts and DoD sharing will be utilized. The Draft National Plan, however, is not simply a compilation of market plans developed at the local level. We also reviewed the plans at the national level and in many cases requested additional analysis by the VISN's. CARES represents the most comprehensive and objective assessment ever completed of the capital infrastructure needed to support VA health care.

OVERVIEW OF THE DRAFT PLAN

In total, the draft National CARES Plan includes recommendations that would result in the following actions:

- 11 million sq. ft. to be renovated
- 9 million sq. ft. to be constructed
- 3.6 million sq. ft. of vacant space eliminated
- reduction of 600 acute hospital beds
- projected annual increase of 18.9 to 12.1 million outpatient clinic stops (in 2012 & 2022, respectively)
 - private sector contracts to meet peak load demand and access
 - 48 new high priority community-based outreach clinics (CBOC's)
 - 2 new hospitals (Orlando, FL, and Las Vegas, NV)
 - 1 replacement hospital (Denver)
 - improved access (in terms of driving time) from 72 percent to 84 percent of enrollees meeting guidelines for access to acute hospitals; and from 94 percent to 97 percent for tertiary care hospitals (2001 vs. 2012 and 2022)
 - maintaining enrollee access at 74 percent within primary care access guidelines, but improving market-level access from 67 percent of markets meeting guidelines to 79 percent, if 48 new proposed CBOC's implemented
 - preservation of current Special Disability Program capacity and addition of new locations:
 - 2 new Blind Rehabilitation Centers (VISN's 16 and 22)
 - 4 new Spinal Cord Injury & Disorders (SCI/D) Units (VISN's 2, 16, 19, and 23)
 - 5 expansions of SCI/D LTC beds (VISN's 8, 9, 10, and 22) and expanded acute/sustaining beds (VISN 7)
 - collaboration within and outside VA:
 - VBA: 13 high priority regional benefits office co-locations
 - NCA: 7 high priority future cemetery use opportunities
 - DoD: 21 high priority collaborations/joint ventures

REALIGNMENTS AND CONSOLIDATIONS

I would like to discuss in more detail the decisions I made regarding realignments of Division II campuses and changing the mission of small facilities. When I reviewed the results of the market plans, I concluded that there were opportunities to realign campuses that improve the quality, access and resource use by examining opportunities to move these campuses from inpatient to outpatient operations, i.e. by converting from 24-hour, 7-days/week to 8-hours, 5-days/week operations. I asked the VISN's to determine how this could be accomplished at selected sites with the provision that there would be no loss of services to veterans. I specified that Inpatient services must be provided at other VAMC's through sharing agreements or community contracts.

Outpatient services were to be maintained on the campus or in the local community through leasing of sites or contracting for care. The realignments focused on moving long-term care sites to sites with an acute care presence because this would also improve access to diagnostic and therapeutic services for the long-term care population. The current physical environment in many sites would require significant capital investment in older buildings that are more expensive to renovate than to build a new Nursing Home for example. In addition, since patients served by long-term care facilities are not geographically concentrated, i.e. they come from larger geographic areas, the relocations do not significantly impact access. Where contracting is combined with relocation of beds to other VAMC's or where relocation is at a site with a greater concentration of veterans, access is improved. The draft National CARES Plan realignments are concept proposals that will be further reviewed and additional cost benefit information will be provided to the Secretary and the CARES Commission prior to the final CARES Plan decision. Should the proposals be improved further, detailed planning would occur as part of implementation planning. In no case would services be discontinued without alternative sites of care available and operational. Any savings or revenues realized from enhanced use leasing of sites will be used to benefit veterans in the communities where the campuses are located.

SMALL FACILITIES

The future of small facilities and their role in the VHA health care system were key components of the CARES process. The issues were how to ensure that veterans will receive the best diagnostic and interventional technologies and whether this is feasible in facilities that are already small and show forecasted declines or remain at similar bed levels. The trend toward more sophisticated imaging and advances in invasive techniques, which shorten hospital stays but require the investment in expensive major equipment, has led to a further consolidation of care in tertiary care facilities of more complex cases. Optimal and efficient functioning of the VA's health care delivery system depends upon early referral and transfer of patients with complicated conditions and those requiring major surgery, where outcomes may be volume-dependent.

These trends have led to declines in bed days of care in smaller facilities to the point at which staff proficiency and outcomes may be compromised in low-volume sites. Moreover, economies of scale in provision of the latest medical and imaging technology cannot be realized. Nevertheless, many small VA medical centers (VAMC's) are important providers of health care in their communities. The CARES review of small facilities in the VA has proposed a Critical Access Hospital (CAH) designation of small facilities, based upon the Center for Medicare and Medicaid Services model, requiring that they meet certain operational standards and restricting their "scope of practice." The intent of this process would be to improve the efficiency, effectiveness, and to enhance the level of functioning of, small facilities within the context of VA's national system of health care delivery. Over the course of the next year, the VA will develop and implement policies to govern the operation of acute beds in small VA facilities, which may fit into a CAH-like model of health care delivery.

ENHANCED USE

Of the top 20 VA facilities identified by the Office of Asset and Enterprise Management (OAEM) as having the highest potential Enhanced Use Lease opportunities, 18 have Enhanced Use Lease initiatives included in the VISN CARES Market Plans. By the end of the CARES planning timeframe, approximately 4.5 million square feet of vacant space is expected to be available for enhanced use lease initiatives. This square footage does not include the acres of land that more than half of the 18 facilities propose for enhanced use lease initiatives.

CONCLUSION

Mr. Chairman, the draft national plan is currently under intensive scrutiny by the Secretary's CARES Commission. Following review of the Commission's recommendations and the subsequent approval of a final National CARES Plan by the Secretary, implementation will take place over a period of many years. It will be a multifaceted process, depending upon whether implementation of specific initiatives requires additional capital, recurring funding, primarily policy changes, or realignments. In particular, the complexity of realigning clinical services and campuses necessitates careful planning in order to ensure a seamless transition in services. In no case would services be discontinued without alternative sites of care being available and operational. And, as I mentioned earlier, savings or revenues realized from enhanced use leasing will be used to benefit veterans in the communities where the affected campuses are located.

This concludes my statement. I will now be happy to answer any questions that you or other members of the Committee might have.

